

91.30 **ARTICLE 4**
91.31 **BEHAVIORAL HEALTH**

91.32 Section 1. Minnesota Statutes 2024, section 245.462, subdivision 20, is amended to read:

91.33 Subd. 20. **Mental illness.** (a) "Mental illness" means an organic disorder of the brain or
91.34 a clinically significant disorder of thought, mood, perception, orientation, memory, or
92.1 behavior that is detailed in a diagnostic codes list published by the commissioner, and that
92.2 seriously limits a person's capacity to function in primary aspects of daily living such as
92.3 personal relations, living arrangements, work, and recreation.

92.4 (b) An "adult with acute mental illness" means an adult who has a mental illness that is
92.5 serious enough to require prompt intervention.

92.6 (c) For purposes of enrolling in case management and community support services, a
92.7 "person with serious and persistent mental illness" means an adult who has a mental illness
92.8 and meets at least one of the following criteria:

92.9 (1) the adult has undergone ~~two~~ one or more episodes of inpatient, residential, or crisis
92.10 residential care for a mental illness within the preceding ~~24~~ 12 months;

92.11 (2) the adult has experienced a continuous psychiatric hospitalization or residential
92.12 treatment exceeding six months' duration within the preceding 12 months;

92.13 (3) the adult has been treated by a crisis team two or more times within the preceding
92.14 24 months;

92.15 (4) the adult:

92.16 (i) has a diagnosis of schizophrenia, bipolar disorder, major depression, schizoaffective
92.17 disorder, post-traumatic stress disorder, or borderline personality disorder;

92.18 (ii) indicates a significant impairment in functioning; and

92.19 (iii) has a written opinion from a mental health professional, in the last three years,
92.20 stating that the adult is reasonably likely to have future episodes requiring inpatient or
92.21 residential treatment, of a frequency described in clause (1) or (2), or the need for in-home
92.22 services to remain in one's home, unless ongoing case management or community support
92.23 services are provided;

92.24 (5) the adult has, in the last ~~three~~ five years, been committed by a court as a person ~~who~~
92.25 ~~is mentally ill~~ with a mental illness under chapter 253B, or the adult's commitment has been
92.26 stayed or continued; or

92.27 (6) ~~the adult (i) was eligible under clauses (1) to (5), but the specified time period has~~
92.28 ~~expired or the adult was eligible as a child under section 245.4871, subdivision 6; and (ii)~~

149.13 **ARTICLE 4**
149.14 **SUBSTANCE USE DISORDER TREATMENT**

264.22 Section 1. Minnesota Statutes 2024, section 245.462, subdivision 20, is amended to read:

264.23 Subd. 20. **Mental illness.** (a) "Mental illness" means an organic disorder of the brain or
264.24 a clinically significant disorder of thought, mood, perception, orientation, memory, or
264.25 behavior that is detailed in a diagnostic codes list published by the commissioner, and that
264.26 seriously limits a person's capacity to function in primary aspects of daily living such as
264.27 personal relations, living arrangements, work, and recreation.

264.28 (b) An "adult with acute mental illness" means an adult who has a mental illness that is
264.29 serious enough to require prompt intervention.

265.1 (c) For purposes of enrolling in case management and community support services, a
265.2 "person with serious and persistent mental illness" means an adult who has a mental illness
265.3 and meets at least one of the following criteria:

265.4 (1) the adult has undergone ~~two~~ one or more episodes of inpatient, residential, or crisis
265.5 residential care for a mental illness within the preceding ~~24~~ 12 months;

265.6 (2) the adult has experienced a continuous psychiatric hospitalization or residential
265.7 treatment exceeding six months' duration within the preceding 12 months;

265.8 (3) the adult has been treated by a crisis team two or more times within the preceding
265.9 24 months;

265.10 (4) the adult:

265.11 (i) has a diagnosis of schizophrenia, bipolar disorder, major depression, schizoaffective
265.12 disorder, post-traumatic stress disorder, generalized anxiety disorder, panic disorder, eating
265.13 disorder, or borderline personality disorder;

265.14 (ii) indicates a significant impairment in functioning; and

265.15 (iii) has a written opinion from a mental health professional, in the last three years,
265.16 stating that the adult is reasonably likely to have future episodes requiring inpatient or
265.17 residential treatment, of a frequency described in clause (1) or (2), or the need for in-home
265.18 services to remain in one's home, unless ongoing case management or community support
265.19 services are provided;

265.20 (5) the adult has, in the last ~~three~~ five years, been committed by a court as a person ~~who~~
265.21 ~~is mentally ill~~ with a mental illness under chapter 253B, or the adult's commitment has been
265.22 stayed or continued; or

265.23 (6) ~~the adult (i) was eligible under clauses (1) to (5), but the specified time period has~~
265.24 ~~expired or the adult was eligible as a child under section 245.4871, subdivision 6; and (ii)~~

92.29 ~~has a written opinion from a mental health professional, in the last three years, stating that~~
92.30 ~~the adult is reasonably likely to have future episodes requiring inpatient or residential~~
92.31 ~~treatment, of a frequency described in clause (1) or (2), unless ongoing case management~~
92.32 ~~or community support services are provided; or~~

93.1 ~~(7) (6)~~ the adult was eligible as a child under section 245.4871, subdivision 6, and is
93.2 age 21 or younger.

93.3 (d) For purposes of enrolling in case management and community support services, a
93.4 "person with a complex post-traumatic stress disorder" or "person with a C-PTSD" means
93.5 an adult who has a mental illness and meets the following criteria:

93.6 (1) the adult has post-traumatic stress disorder (PTSD) symptoms that significantly
93.7 interfere with daily functioning related to intergenerational trauma, racial trauma, or
93.8 unresolved historical grief; and

93.9 (2) the adult has a written opinion from a mental health professional that includes
93.10 documentation of:

93.11 (i) culturally sensitive assessments or screenings and identification of intergenerational
93.12 trauma, racial trauma, or unresolved historical grief;

93.13 (ii) significant impairment in functioning due to the PTSD symptoms that meet C-PTSD
93.14 condition eligibility; and

93.15 (iii) increasing concerns within the last three years that indicate there is a reasonable
93.16 likelihood the adult will experience significant episodes of PTSD with increased frequency,
93.17 impacting daily functioning, unless mitigated by targeted case management or community
93.18 support services.

93.19 (e) Adults may continue to receive case management or community support services if,
93.20 in the written opinion of a mental health professional, the person needs case management
93.21 or community support services to maintain the person's recovery.

93.22 EFFECTIVE DATE. Paragraph (d) is effective upon federal approval. The commissioner
93.23 of human services shall notify the revisor of statutes when federal approval is obtained.

93.24 Sec. 2. Minnesota Statutes 2024, section 245.4661, subdivision 2, is amended to read:

93.25 Subd. 2. **Program design and implementation.** Adult mental health initiatives shall
93.26 be responsible for designing, planning, improving, and maintaining a mental health service
93.27 delivery system for adults with serious and persistent mental illness that would:

93.28 (1) provide an expanded array of services from which clients can choose services
93.29 appropriate to their needs;

93.30 (2) be based on purchasing strategies that improve access and coordinate services without
93.31 cost shifting;

265.25 ~~has a written opinion from a mental health professional, in the last three years, stating that~~
265.26 ~~the adult is reasonably likely to have future episodes requiring inpatient or residential~~
265.27 ~~treatment, of a frequency described in clause (1) or (2), unless ongoing case management~~
265.28 ~~or community support services are provided; or~~

265.29 ~~(7) (6)~~ the adult was eligible as a child under section 245.4871, subdivision 6, and is
265.30 age 21 or younger.

266.1 (d) For purposes of enrolling in case management and community support services, a
266.2 "person with a complex post-traumatic stress disorder" or "C-PTSD" means an adult who
266.3 has a mental illness and meets the following criteria:

266.4 (1) the adult has post-traumatic stress disorder (PTSD) symptoms that significantly
266.5 interfere with daily functioning related to intergenerational trauma, racial trauma, or
266.6 unresolved historical grief; and

266.7 (2) the adult has a written opinion from a mental health professional that includes
266.8 documentation of:

266.9 (i) culturally sensitive assessments or screenings and identification of intergenerational
266.10 trauma, racial trauma, or unresolved historical grief;

266.11 (ii) significant impairment in functioning due to the PTSD symptoms that meet C-PTSD
266.12 condition eligibility; and

266.13 (iii) increasing concerns within the last three years that indicates the adult is at a
266.14 reasonable likelihood of experiencing significant episodes of PTSD with increased frequency,
266.15 impacting daily functioning unless mitigated by targeted case management or community
266.16 support services.

266.17 (e) Adults may continue to receive case management or community support services if,
266.18 in the written opinion of a mental health professional, the person needs case management
266.19 or community support services to maintain the person's recovery.

266.20 EFFECTIVE DATE. Paragraph (d) is effective upon federal approval. The commissioner
266.21 of human services shall notify the revisor of statutes when federal approval is obtained.

266.22 Sec. 2. Minnesota Statutes 2024, section 245.4661, subdivision 2, is amended to read:

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266.26 (1) provide an expanded array of services from which clients can choose services
266.27 appropriate to their needs;

266.28 (2) be based on purchasing strategies that improve access and coordinate services without
266.29 cost shifting;

94.1 (3) prioritize evidence-based services and implement services that are promising practices
94.2 or theory-based practices so that the service can be evaluated according to subdivision 5a;

94.3 (4) incorporate existing state facilities and resources into the community mental health
94.4 infrastructure through creative partnerships with local vendors; and

94.5 (5) utilize ~~existing categorical funding streams and reimbursement sources in combined~~
94.6 ~~and creative ways, except adult mental health initiative funding only after all other eligible~~
94.7 ~~funding sources have been applied.~~ Appropriations and all funds that are attributable to the
94.8 operation of state-operated services under the control of the Direct Care and Treatment
94.9 executive board are excluded unless appropriated specifically by the legislature for a purpose
94.10 consistent with this section.

94.11 Sec. 3. Minnesota Statutes 2024, section 245.4661, subdivision 6, is amended to read:

94.12 Subd. 6. **Duties of commissioner.** (a) For purposes of adult mental health initiatives,
94.13 the commissioner shall facilitate integration of funds or other resources as needed and
94.14 requested by each adult mental health initiative. These resources may include:

94.15 (1) community support services funds administered under Minnesota Rules, parts
94.16 9535.1700 to 9535.1760;

94.17 (2) other mental health special project funds;

94.18 (3) medical assistance, MinnesotaCare, and housing support under chapter 256I if
94.19 requested by the adult mental health initiative's managing entity and if the commissioner
94.20 determines this would be consistent with the state's overall health care reform efforts; and

94.21 (4) regional treatment center resources, with consent from the Direct Care and Treatment
94.22 executive board.

94.23 ~~(b) The commissioner shall consider the following criteria in awarding grants for adult~~
94.24 ~~mental health initiatives:~~

94.25 ~~(1) the ability of the initiatives to accomplish the objectives described in subdivision 2;~~
94.26 ~~(2) the size of the target population to be served; and~~
94.27 ~~(3) geographical distribution.~~

94.28 ~~(c)~~ (b) The commissioner shall review overall status of the initiatives at least every two
94.29 years and recommend any legislative changes needed by January 15 of each odd-numbered
94.30 year.

95.1 ~~(d)~~ (c) The commissioner may waive administrative rule requirements that are
95.2 incompatible with the implementation of the adult mental health initiative.

95.3 ~~(e)~~ (d) The commissioner may exempt the participating counties from fiscal sanctions
95.4 for noncompliance with requirements in laws and rules that are incompatible with the
95.5 implementation of the adult mental health initiative.

266.30 (3) prioritize evidence-based services and implement services that are promising practices
266.31 or theory-based practices so that the service can be evaluated according to subdivision 5a;

267.1 (4) incorporate existing state facilities and resources into the community mental health
267.2 infrastructure through creative partnerships with local vendors; and

267.3 (5) utilize ~~existing categorical funding streams and reimbursement sources in combined~~
267.4 ~~and creative ways, except adult mental health initiative funding only after all other eligible~~
267.5 ~~funding sources have been applied.~~ Appropriations and all funds that are attributable to the
267.6 operation of state-operated services under the control of the Direct Care and Treatment
267.7 executive board are excluded unless appropriated specifically by the legislature for a purpose
267.8 consistent with this section.

267.9 Sec. 3. Minnesota Statutes 2024, section 245.4661, subdivision 6, is amended to read:

267.10 Subd. 6. **Duties of commissioner.** (a) For purposes of adult mental health initiatives,
267.11 the commissioner shall facilitate integration of funds or other resources as needed and
267.12 requested by each adult mental health initiative. These resources may include:

267.13 (1) community support services funds administered under Minnesota Rules, parts
267.14 9535.1700 to 9535.1760;

267.15 (2) other mental health special project funds;

267.16 (3) medical assistance, MinnesotaCare, and housing support under chapter 256I if
267.17 requested by the adult mental health initiative's managing entity and if the commissioner
267.18 determines this would be consistent with the state's overall health care reform efforts; and

267.19 (4) regional treatment center resources, with consent from the Direct Care and Treatment
267.20 executive board.

267.21 ~~(b) The commissioner shall consider the following criteria in awarding grants for adult~~
267.22 ~~mental health initiatives:~~

267.23 ~~(1) the ability of the initiatives to accomplish the objectives described in subdivision 2;~~
267.24 ~~(2) the size of the target population to be served; and~~
267.25 ~~(3) geographical distribution.~~

267.26 ~~(c)~~ (b) The commissioner shall review overall status of the initiatives at least every two
267.27 years and recommend any legislative changes needed by January 15 of each odd-numbered
267.28 year.

267.29 ~~(d)~~ (c) The commissioner may waive administrative rule requirements that are
267.30 incompatible with the implementation of the adult mental health initiative.

268.1 ~~(e)~~ (d) The commissioner may exempt the participating counties from fiscal sanctions
268.2 for noncompliance with requirements in laws and rules that are incompatible with the
268.3 implementation of the adult mental health initiative.

95.6 ~~(f)~~ (e) The commissioner may award grants to an entity designated by a county board
95.7 or group of county boards to pay for start-up and implementation costs of the adult mental
95.8 health initiative.

95.9 Sec. 4. Minnesota Statutes 2024, section 245.4661, subdivision 7, is amended to read:

95.10 Subd. 7. **Duties of adult mental health initiative board.** The adult mental health
95.11 initiative board, or other entity which is approved to administer an adult mental health
95.12 initiative, shall:

95.13 (1) administer the initiative in a manner that is consistent with the objectives described
95.14 in subdivision 2 and the planning process described in subdivision 5;

95.15 (2) assure that no one is denied services that they would otherwise be eligible for; and

95.16 (3) provide the commissioner of human services with timely and pertinent information
95.17 through ~~the following methods:~~

95.18 ~~(i) submission of mental health plans and plan amendments which are based on a format~~
95.19 ~~and timetable determined by the commissioner;~~

95.20 ~~(ii) submission of social services expenditure and grant reconciliation reports, based on~~
95.21 ~~a coding format to be determined by mutual agreement between the initiative's managing~~
95.22 ~~entity and the commissioner; and~~

95.23 ~~(iii) submission of data and participation in an evaluation of the adult mental health~~
95.24 ~~initiatives, to be designed cooperatively by the commissioner and the initiatives. For services~~
95.25 ~~provided to American Indians in Tribal nations or urban Indian communities, oral reports~~
95.26 ~~using a system designed in partnership between the commissioner and the reporting~~
95.27 ~~community satisfy the requirements of this clause.~~

95.28 Sec. 5. Minnesota Statutes 2024, section 245.467, subdivision 4, is amended to read:

95.29 Subd. 4. **Referral for case management.** Each provider of emergency services, day
95.30 treatment services, outpatient treatment, community support services, residential treatment,
95.31 acute care hospital inpatient treatment, or regional treatment center inpatient treatment must
96.1 inform each of its clients with serious and persistent mental illness or a complex
96.2 post-traumatic stress disorder of the availability and potential benefits to the client of case
96.3 management. If the client consents, the provider must refer the client by notifying the county
96.4 employee designated by the county board to coordinate case management activities of the
96.5 client's name and address and by informing the client of whom to contact to request case
96.6 management. The provider must document compliance with this subdivision in the client's
96.7 record.

96.8 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
96.9 of human services shall notify the revisor of statutes when federal approval is obtained.

268.4 ~~(f)~~ (e) The commissioner may award grants to an entity designated by a county board
268.5 or group of county boards to pay for start-up and implementation costs of the adult mental
268.6 health initiative.

268.7 Sec. 4. Minnesota Statutes 2024, section 245.4661, subdivision 7, is amended to read:

268.8 Subd. 7. **Duties of adult mental health initiative board.** The adult mental health
268.9 initiative board, or other entity which is approved to administer an adult mental health
268.10 initiative, shall:

268.11 (1) administer the initiative in a manner that is consistent with the objectives described
268.12 in subdivision 2 and the planning process described in subdivision 5;

268.13 (2) assure that no one is denied services that they would otherwise be eligible for; and

268.14 (3) provide the commissioner of human services with timely and pertinent information
268.15 through ~~the following methods:~~

268.16 ~~(i) submission of mental health plans and plan amendments which are based on a format~~
268.17 ~~and timetable determined by the commissioner;~~

268.18 ~~(ii) submission of social services expenditure and grant reconciliation reports, based on~~
268.19 ~~a coding format to be determined by mutual agreement between the initiative's managing~~
268.20 ~~entity and the commissioner; and~~

268.21 ~~(iii) submission of data and participation in an evaluation of the adult mental health~~
268.22 ~~initiatives, to be designed cooperatively by the commissioner and the initiatives. For services~~
268.23 ~~provided to American Indians in Tribal Nations or urban Indian communities, oral reports~~
268.24 ~~using a system designed in partnership between the commissioner and the reporting~~
268.25 ~~community satisfy the requirements of this clause.~~

268.26 Sec. 5. Minnesota Statutes 2024, section 245.467, subdivision 4, is amended to read:

268.27 Subd. 4. **Referral for case management.** Each provider of emergency services, day
268.28 treatment services, outpatient treatment, community support services, residential treatment,
268.29 acute care hospital inpatient treatment, or regional treatment center inpatient treatment must
268.30 inform each of its clients with serious and persistent mental illness or a complex
268.31 post-traumatic stress disorder of the availability and potential benefits to the client of case
269.1 management. If the client consents, the provider must refer the client by notifying the county
269.2 employee designated by the county board to coordinate case management activities of the
269.3 client's name and address and by informing the client of whom to contact to request case
269.4 management. The provider must document compliance with this subdivision in the client's
269.5 record.

269.6 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
269.7 of human services shall notify the revisor of statutes when federal approval is obtained.

96.10 Sec. 6. Minnesota Statutes 2024, section 245.4711, subdivision 1, is amended to read:

96.11 Subdivision 1. **Availability of case management services.** (a) ~~By January 1, 1989,~~ The

96.12 county board shall provide case management services for all adults with serious and persistent

96.13 mental illness or a complex post-traumatic stress disorder who are residents of the county

96.14 and who request or consent to the services and to each adult for whom the court appoints a

96.15 case manager. Staffing ratios must be sufficient to serve the needs of the clients. The case

96.16 manager must meet the requirements in section 245.462, subdivision 4.

96.17 (b) Case management services provided to adults with serious and persistent mental

96.18 illness or a complex post-traumatic stress disorder eligible for medical assistance must be

96.19 billed to the medical assistance program under sections 256B.02, subdivision 8, and

96.20 256B.0625.

96.21 (c) Case management services are eligible for reimbursement under the medical assistance

96.22 program. Costs associated with mentoring, supervision, and continuing education may be

96.23 included in the reimbursement rate methodology used for case management services under

96.24 the medical assistance program.

96.25 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner

96.26 of human services shall notify the revisor of statutes when federal approval is obtained.

96.27 Sec. 7. Minnesota Statutes 2024, section 245.4711, subdivision 4, is amended to read:

96.28 Subd. 4. **Individual community support plan.** (a) The case manager must develop an

96.29 individual community support plan for each adult that incorporates the client's individual

96.30 treatment plan. The individual treatment plan may not be a substitute for the development

96.31 of an individual community support plan. The individual community support plan must be

96.32 developed within 30 days of client intake and reviewed at least every 180 days after it is

97.1 developed, unless the case manager receives a written request from the client or the client's

97.2 family for a review of the plan every 90 days after it is developed. The case manager is

97.3 responsible for developing the individual community support plan based on a diagnostic

97.4 assessment and a functional assessment and for implementing and monitoring the delivery

97.5 of services according to the individual community support plan. To the extent possible, the

97.6 adult with serious and persistent mental illness or a complex post-traumatic stress disorder,

97.7 the person's family, advocates, service providers, and significant others must be involved

97.8 in all phases of development and implementation of the individual community support plan.

97.9 (b) The client's individual community support plan must state:

97.10 (1) the goals of each service;

97.11 (2) the activities for accomplishing each goal;

97.12 (3) a schedule for each activity; and

97.13 (4) the frequency of face-to-face contacts by the case manager, as appropriate to client

97.14 need and the implementation of the individual community support plan.

269.8 Sec. 6. Minnesota Statutes 2024, section 245.4711, subdivision 1, is amended to read:

269.9 Subdivision 1. **Availability of case management services.** (a) ~~By January 1, 1989,~~ The

269.10 county board shall provide case management services for all adults with serious and persistent

269.11 mental illness or a complex post-traumatic stress disorder who are residents of the county

269.12 and who request or consent to the services and to each adult for whom the court appoints a

269.13 case manager. Staffing ratios must be sufficient to serve the needs of the clients. The case

269.14 manager must meet the requirements in section 245.462, subdivision 4.

269.15 (b) Case management services provided to adults with serious and persistent mental

269.16 illness or a complex post-traumatic stress disorder eligible for medical assistance must be

269.17 billed to the medical assistance program under sections 256B.02, subdivision 8, and

269.18 256B.0625.

269.19 (c) Case management services are eligible for reimbursement under the medical assistance

269.20 program. Costs associated with mentoring, supervision, and continuing education may be

269.21 included in the reimbursement rate methodology used for case management services under

269.22 the medical assistance program.

269.23 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner

269.24 of human services shall notify the revisor of statutes when federal approval is obtained.

269.25 Sec. 7. Minnesota Statutes 2024, section 245.4711, subdivision 4, is amended to read:

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269.27 individual community support plan for each adult that incorporates the client's individual

269.28 treatment plan. The individual treatment plan may not be a substitute for the development

269.29 of an individual community support plan. The individual community support plan must be

269.30 developed within 30 days of client intake and reviewed at least every 180 days after it is

269.31 developed, unless the case manager receives a written request from the client or the client's

269.32 family for a review of the plan every 90 days after it is developed. The case manager is

270.1 responsible for developing the individual community support plan based on a diagnostic

270.2 assessment and a functional assessment and for implementing and monitoring the delivery

270.3 of services according to the individual community support plan. To the extent possible, the

270.4 adult with serious and persistent mental illness or a complex post-traumatic stress disorder,

270.5 the person's family, advocates, service providers, and significant others must be involved

270.6 in all phases of development and implementation of the individual community support plan.

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270.8 (1) the goals of each service;

270.9 (2) the activities for accomplishing each goal;

270.10 (3) a schedule for each activity; and

270.11 (4) the frequency of face-to-face contacts by the case manager, as appropriate to client

270.12 need and the implementation of the individual community support plan.

97.15 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
97.16 of human services shall notify the revisor of statutes when federal approval is obtained.

97.17 Sec. 8. Minnesota Statutes 2024, section 245.4712, subdivision 1, is amended to read:

97.18 Subdivision 1. **Availability of community support services.** (a) County boards must
97.19 provide or contract for sufficient community support services within the county to meet the
97.20 needs of adults with serious and persistent mental illness or a complex post-traumatic stress
97.21 disorder who are residents of the county. Adults may be required to pay a fee according to
97.22 section 245.481. The community support services program must be designed to improve
97.23 the ability of adults with serious and persistent mental illness or a complex post-traumatic
97.24 stress disorder to:

97.25 (1) find and maintain competitive employment;

97.26 (2) handle basic activities of daily living;

97.27 (3) participate in leisure time activities;

97.28 (4) set goals and plans; and

97.29 (5) obtain and maintain appropriate living arrangements.

98.1 The community support services program must also be designed to reduce the need for
98.2 and use of more intensive, costly, or restrictive placements both in number of admissions
98.3 and length of stay.

98.4 (b) Community support services are those services that are supportive in nature and not
98.5 necessarily treatment oriented, and include:

98.6 (1) conducting outreach activities such as home visits, health and wellness checks, and
98.7 problem solving;

98.8 (2) connecting people to resources to meet their basic needs;

98.9 (3) finding, securing, and supporting people in their housing;

98.10 (4) attaining and maintaining health insurance benefits;

98.11 (5) assisting with job applications, finding and maintaining employment, and securing
98.12 a stable financial situation;

98.13 (6) fostering social support, including support groups, mentoring, peer support, and other
98.14 efforts to prevent isolation and promote recovery; and

98.15 (7) educating about mental illness, treatment, and recovery.

98.16 (c) Community support services shall use all available funding streams. The county shall
98.17 maintain the level of expenditures for this program, as required under section 245.4835.

98.18 County boards must continue to provide funds for those services not covered by other
98.19 funding streams and to maintain an infrastructure to carry out these services. The county is

270.13 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
270.14 of human services shall notify the revisor of statutes when federal approval is obtained.

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270.19 disorder who are residents of the county. Adults may be required to pay a fee according to
270.20 section 245.481. The community support services program must be designed to improve
270.21 the ability of adults with serious and persistent mental illness or a complex post-traumatic
270.22 stress disorder to:

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270.29 and use of more intensive, costly, or restrictive placements both in number of admissions
270.30 and length of stay.

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271.2 necessarily treatment oriented, and include:

271.3 (1) conducting outreach activities such as home visits, health and wellness checks, and
271.4 problem solving;

271.5 (2) connecting people to resources to meet their basic needs;

271.6 (3) finding, securing, and supporting people in their housing;

271.7 (4) attaining and maintaining health insurance benefits;

271.8 (5) assisting with job applications, finding and maintaining employment, and securing
271.9 a stable financial situation;

271.10 (6) fostering social support, including support groups, mentoring, peer support, and other
271.11 efforts to prevent isolation and promote recovery; and

271.12 (7) educating about mental illness, treatment, and recovery.

271.13 (c) Community support services shall use all available funding streams. The county shall
271.14 maintain the level of expenditures for this program, as required under section 245.4835.

271.15 County boards must continue to provide funds for those services not covered by other
271.16 funding streams and to maintain an infrastructure to carry out these services. The county is

98.20 encouraged to fund evidence-based practices such as Individual Placement and Supported
98.21 Employment and Illness Management and Recovery.

98.22 (d) The commissioner shall collect data on community support services programs,
98.23 including, but not limited to, demographic information such as age, sex, race, the number
98.24 of people served, and information related to housing, employment, hospitalization, symptoms,
98.25 and satisfaction with services.

98.26 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
98.27 of human services shall notify the revisor of statutes when federal approval is obtained.

98.28 Sec. 9. Minnesota Statutes 2024, section 245.4712, subdivision 3, is amended to read:

98.29 Subd. 3. **Benefits assistance.** The county board must offer to help adults with serious
98.30 and persistent mental illness or a complex post-traumatic stress disorder in applying for
98.31 state and federal benefits, including Supplemental Security Income, medical assistance,
99.1 Medicare, general assistance, and Minnesota supplemental aid. The help must be offered
99.2 as part of the community support program available to adults with serious and persistent
99.3 mental illness or a complex post-traumatic stress disorder for whom the county is financially
99.4 responsible and who may qualify for these benefits.

99.5 Sec. 10. Minnesota Statutes 2024, section 245.4871, subdivision 5, is amended to read:

99.6 Subd. 5. **Child.** "Child" means a person under 18 years of age, or a person 18 years of
99.7 age or older and under 21 years of age receiving continuous children's mental health targeted
99.8 case management services under section 245.4881.

271.17 encouraged to fund evidence-based practices such as Individual Placement and Supported
271.18 Employment and Illness Management and Recovery.

271.19 (d) The commissioner shall collect data on community support services programs,
271.20 including, but not limited to, demographic information such as age, sex, race, the number
271.21 of people served, and information related to housing, employment, hospitalization, symptoms,
271.22 and satisfaction with services.

271.23 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
271.24 of human services shall notify the revisor of statutes when federal approval is obtained.

271.25 Sec. 9. Minnesota Statutes 2024, section 245.4712, subdivision 3, is amended to read:

271.26 Subd. 3. **Benefits assistance.** The county board must offer to help adults with serious
271.27 and persistent mental illness or a complex post-traumatic stress disorder in applying for
271.28 state and federal benefits, including Supplemental Security Income, medical assistance,
271.29 Medicare, general assistance, and Minnesota supplemental aid. The help must be offered
271.30 as part of the community support program available to adults with serious and persistent
271.31 mental illness or a complex post-traumatic stress disorder for whom the county is financially
271.32 responsible and who may qualify for these benefits.

272.1 Sec. 10. Minnesota Statutes 2024, section 245.4871, subdivision 5, is amended to read:

272.2 Subd. 5. **Child.** "Child" means a person under 18 years of age, or a person 18 years of
272.3 age or older and under 21 years of age receiving continuous children's mental health targeted
272.4 case management services as defined in section 245.4875, subdivision 8.

272.5 Sec. 11. Minnesota Statutes 2024, section 245.4889, subdivision 1, is amended to read:

272.6 Subdivision 1. **Establishment and authority.** (a) The commissioner is authorized to
272.7 make grants from available appropriations to assist:

272.8 (1) counties;

272.9 (2) Indian tribes;

272.10 (3) children's collaboratives under section 142D.15 or 245.493; or

272.11 (4) mental health service providers.

272.12 (b) The following services are eligible for grants under this section:

272.13 (1) services to children with emotional disturbances as defined in section 245.4871,
272.14 subdivision 15, and their families;

272.15 (2) transition services under section 245.4875, subdivision 8, for young adults under
272.16 age 21 and their families;

272.17 (3) respite care services for children with emotional disturbances or severe emotional
272.18 disturbances who are at risk of residential treatment or hospitalization, who are already in

- 272.19 out-of-home placement in family foster settings as defined in chapter 142B and at risk of
272.20 change in out-of-home placement or placement in a residential facility or other higher level
272.21 of care, who have utilized crisis services or emergency room services, or who have
272.22 experienced a loss of in-home staffing support. Allowable activities and expenses for respite
272.23 care services are defined under subdivision 4. A child is not required to have case
272.24 management services to receive respite care services. Counties must work to provide access
272.25 to regularly scheduled respite care;
- 272.26 (4) children's mental health crisis services;
- 272.27 (5) child-, youth-, and family-specific mobile response and stabilization services models;
- 272.28 (6) mental health services for people from cultural and ethnic minorities, including
272.29 supervision of clinical trainees who are Black, indigenous, or people of color;
- 272.30 (7) children's mental health screening and follow-up diagnostic assessment and treatment;
- 273.1 (8) services to promote and develop the capacity of providers to use evidence-based
273.2 practices in providing children's mental health services;
- 273.3 (9) school-linked mental health services under section 245.4901;
- 273.4 (10) building evidence-based mental health intervention capacity for children birth to
273.5 age five;
- 273.6 (11) suicide prevention and counseling services that use text messaging statewide;
- 273.7 (12) mental health first aid training;
- 273.8 (13) training for parents, collaborative partners, and mental health providers on the
273.9 impact of adverse childhood experiences and trauma and development of an interactive
273.10 website to share information and strategies to promote resilience and prevent trauma;
- 273.11 (14) transition age services to develop or expand mental health treatment and supports
273.12 for adolescents and young adults 26 years of age or younger;
- 273.13 (15) early childhood mental health consultation;
- 273.14 (16) evidence-based interventions for youth at risk of developing or experiencing a first
273.15 episode of psychosis, and a public awareness campaign on the signs and symptoms of
273.16 psychosis;
- 273.17 (17) psychiatric consultation for primary care practitioners; ~~and~~
- 273.18 (18) providers to begin operations and meet program requirements when establishing a
273.19 new children's mental health program. These may be start-up grants; and
- 273.20 (19) evidence-based interventions for youth and young adults at risk of developing or
273.21 experiencing an early episode of bipolar disorder.

273.22 (c) Services under paragraph (b) must be designed to help each child to function and
273.23 remain with the child's family in the community and delivered consistent with the child's
273.24 treatment plan. Transition services to eligible young adults under this paragraph must be
273.25 designed to foster independent living in the community.

273.26 (d) As a condition of receiving grant funds, a grantee shall obtain all available third-party
273.27 reimbursement sources, if applicable.

273.28 (e) The commissioner may establish and design a pilot program to expand the mobile
273.29 response and stabilization services model for children, youth, and families. The commissioner
273.30 may use grant funding to consult with a qualified expert entity to assist in the formulation
274.1 of measurable outcomes and explore and position the state to submit a Medicaid state plan
274.2 amendment to scale the model statewide.

274.3 Sec. 12. Minnesota Statutes 2024, section 245.4905, is amended to read:

274.4 **245.4905 FIRST EPISODE OF PSYCHOSIS AND EARLY EPISODE OF**
274.5 **BIPOLAR DISORDER GRANT PROGRAM.**

274.6 Subdivision 1. ~~Creation~~ **Establishment.** The commissioner of human services must
274.7 establish the first episode of psychosis and early episode of bipolar disorder grant program
274.8 ~~is established in the Department of Human Services~~ within the department to fund: (1)
274.9 evidence-based interventions for youth and young adults at risk of developing or experiencing
274.10 a first episode of psychosis or an early episode of bipolar disorder; and (2) a public awareness
274.11 campaign on the signs and symptoms of psychosis. ~~First episode of psychosis services are~~
274.12 ~~eligible for children's mental health grants as specified in section 245.4889, subdivision 1,~~
274.13 ~~paragraph (b), clause (15)~~ For purposes of this section, "youth and young adults" means
274.14 individuals who are 15 years of age or older and under 41 years of age.

274.15 Subd. 2. **Activities.** (a) All first episode of psychosis ~~grant programs~~ or early episode
274.16 of bipolar disorder grantees must:

274.17 (1) provide intensive treatment and support for ~~adolescents and~~ youth and young adults
274.18 experiencing or at risk of experiencing a first ~~psychotic~~ episode of psychosis or early episodes
274.19 of bipolar disorder. Intensive treatment and support ~~includes~~ may include medication
274.20 management, psychoeducation for an individual and an individual's family, case management,
274.21 employment support, education support, cognitive behavioral approaches, social skills
274.22 training, peer and family peer support, crisis planning, and stress management;

274.23 (2) conduct outreach and provide training and guidance to mental health and health care
274.24 professionals, including postsecondary health clinicians, on early psychosis and bipolar
274.25 disorder symptoms, screening tools, and best practices;

274.26 (3) ensure access for individuals to first ~~psychotic~~ episode of psychosis services under
274.27 this section, including access for individuals who live in rural areas; and

274.28 (4) use all available funding streams.

99.9 Sec. 11. Minnesota Statutes 2024, section 245.735, subdivision 3, is amended to read:

99.10 Subd. 3. **Certified community behavioral health clinics.** (a) The commissioner shall
99.11 establish state certification and recertification processes for certified community behavioral
99.12 health clinics (CCBHCs) that satisfy all federal requirements necessary for CCBHCs certified
99.13 under this section to be eligible for reimbursement under medical assistance, without service
99.14 area limits based on geographic area or region. The commissioner shall consult with CCBHC
99.15 stakeholders before establishing and implementing changes in the certification or
99.16 recertification process and requirements. Any changes to the certification or recertification
99.17 process or requirements must be consistent with the most recently issued Certified
99.18 Community Behavioral Health Clinic Certification Criteria published by the Substance
99.19 Abuse and Mental Health Services Administration. The commissioner must allow a transition
99.20 period for CCBHCs to meet the revised criteria on or before January 1, 2025. The

274.29 (b) Grant money may ~~also~~ be used to pay for housing or travel expenses for individuals
274.30 receiving services or to address other barriers preventing individuals and their families from
274.31 participating in first ~~psychotic~~ episode of psychosis services.

275.1 Subd. 3. **Eligibility Funding.** ~~Program activities must be provided to people 15 to 40~~
275.2 ~~years old with early signs of psychosis~~ First episode of psychosis services and early episode
275.3 of bipolar disorder services are eligible for children's mental health grants as specified in
275.4 section 245.4889, subdivision 1, paragraph (b), clauses (16) and (19).

275.5 Subd. 4. **Outcomes.** (a) The commissioner must annually evaluate the first episode of
275.6 psychosis and early episode of bipolar disorder grant program.

275.7 (b) The evaluation of ~~program activities~~ must utilize evidence-based practices and must
275.8 include the following outcome evaluation criteria:

275.9 (1) whether individuals experience a reduction in ~~psychotic~~ symptoms;

275.10 (2) whether individuals experience a decrease in inpatient mental health hospitalizations
275.11 or interactions with the criminal justice system; and

275.12 (3) whether individuals experience an increase in educational attainment or employment.

275.13 (c) By July 1, 2026, and every July 1 thereafter, the commissioner must provide a report
275.14 to the chairs and ranking minority members of the legislative committees with jurisdiction
275.15 over behavioral health, along with the chairs and ranking minority members of the senate
275.16 finance committee and house of representatives ways and means committee. The report
275.17 must include the number of grantees receiving funds under this section, the number of
275.18 individuals served under this section, data from the evaluation conducted under this
275.19 subdivision, and information on the use of state and federal funds for the services provided
275.20 under this section.

275.21 Subd. 5. **Federal aid or grants.** The commissioner of human services must comply with
275.22 all conditions and requirements necessary to receive federal aid or grants.

99.21 commissioner is authorized to amend the state's Medicaid state plan or the terms of the
99.22 demonstration to comply with federal requirements.

99.23 (b) As part of the state CCBHC certification and recertification processes, the
99.24 commissioner shall provide to entities applying for certification or requesting recertification
99.25 the standard requirements of the community needs assessment and the staffing plan that are
99.26 consistent with the most recently issued Certified Community Behavioral Health Clinic
99.27 Certification Criteria published by the Substance Abuse and Mental Health Services
99.28 Administration.

99.29 (c) The commissioner shall schedule a certification review that includes a site visit within
99.30 90 calendar days of receipt of an application for certification or recertification.

99.31 (d) Entities that choose to be CCBHCs must:

100.1 (1) complete a community needs assessment and complete a staffing plan that is
100.2 responsive to the needs identified in the community needs assessment and update both the
100.3 community needs assessment and the staffing plan no less frequently than every 36 months;

100.4 (2) comply with state licensing requirements and other requirements issued by the
100.5 commissioner;

100.6 (3) employ or contract with a medical director. A medical director must be a physician
100.7 licensed under chapter 147 and either certified by the American Board of Psychiatry and
100.8 Neurology, certified by the American Osteopathic Board of Neurology and Psychiatry, or
100.9 eligible for board certification in psychiatry. A registered nurse who is licensed under
100.10 sections 148.171 to 148.285 and is certified as a nurse practitioner in adult or family
100.11 psychiatric and mental health nursing by a national nurse certification organization may
100.12 serve as the medical director when a CCBHC is unable to employ or contract a qualified
100.13 physician;

100.14 (4) employ or contract for clinic staff who have backgrounds in diverse disciplines,
100.15 including licensed mental health professionals and licensed alcohol and drug counselors,
100.16 and staff who are culturally and linguistically trained to meet the needs of the population
100.17 the clinic serves;

100.18 (5) ensure that clinic services are available and accessible to individuals and families of
100.19 all ages and genders with access on evenings and weekends and that crisis management
100.20 services are available 24 hours per day;

100.21 (6) establish fees for clinic services for individuals who are not enrolled in medical
100.22 assistance using a sliding fee scale that ensures that services to patients are not denied or
100.23 limited due to an individual's inability to pay for services;

100.24 (7) comply with quality assurance reporting requirements and other reporting
100.25 requirements included in the most recently issued Certified Community Behavioral Health
100.26 Clinic Certification Criteria published by the Substance Abuse and Mental Health Services
100.27 Administration;

100.28 (8) provide crisis mental health and substance use services, withdrawal management
100.29 services, emergency crisis intervention services, and stabilization services through existing
100.30 mobile crisis services; screening, assessment, and diagnosis services, including risk
100.31 assessments and level of care determinations; person- and family-centered treatment planning;
100.32 outpatient mental health and substance use services; targeted case management; psychiatric
100.33 rehabilitation services; peer support and counselor services and family support services;
100.34 and intensive community-based mental health services, including mental health services
101.1 for members of the armed forces and veterans. CCBHCs must directly provide the majority
101.2 of these services to enrollees, but may coordinate some services with another entity through
101.3 a collaboration or agreement, pursuant to subdivision 3a;

101.4 (9) provide coordination of care across settings and providers to ensure seamless
101.5 transitions for individuals being served across the full spectrum of health services, including
101.6 acute, chronic, and behavioral needs;

101.7 (10) be certified as a mental health clinic under section 245I.20;

101.8 (11) comply with standards established by the commissioner relating to CCBHC
101.9 screenings, assessments, and evaluations that are consistent with this section;

101.10 (12) be licensed to provide substance use disorder treatment under chapter 245G;

101.11 (13) be certified to provide children's therapeutic services and supports under section
101.12 256B.0943;

101.13 (14) be certified to provide adult rehabilitative mental health services under section
101.14 256B.0623;

101.15 (15) be enrolled to provide mental health crisis response services under section
101.16 256B.0624;

101.17 (16) be enrolled to provide mental health targeted case management under section
101.18 256B.0625, subdivision 20;

101.19 (17) provide services that comply with the evidence-based practices described in
101.20 subdivision 3d;

101.21 (18) provide peer services as defined in sections 256B.0615, 256B.0616, and 245G.07,
101.22 subdivision 2 2a, paragraph (b), clause ~~(8)~~ (2), as applicable when peer services are provided;
101.23 and

101.24 (19) inform all clients upon initiation of care of the full array of services available under
101.25 the CCBHC model.

101.26 Sec. 12. Minnesota Statutes 2024, section 245.91, subdivision 4, is amended to read:

101.27 Subd. 4. **Facility or program.** "Facility" or "program" means a nonresidential or
101.28 residential program as defined in section 245A.02, subdivisions 10 and 14, and any agency,
101.29 facility, or program that provides services or treatment for mental illness, developmental

101.30 disability, substance use disorder, or emotional disturbance that is required to be licensed,
101.31 certified, or registered by the commissioner of human services, health, or education; a ~~seber~~
102.1 ~~home~~ recovery residence as defined in section 254B.01, subdivision 11; peer recovery
102.2 support services provided by a recovery community organization as defined in section
102.3 254B.01, subdivision 8; and an acute care inpatient facility that provides services or treatment
102.4 for mental illness, developmental disability, substance use disorder, or emotional disturbance.

102.5 **EFFECTIVE DATE.** This section is effective January 1, 2027.

102.6 Sec. 13. Minnesota Statutes 2024, section 245F.08, subdivision 3, is amended to read:

102.7 Subd. 3. **Peer recovery support services.** Peer recovery support services must meet the
102.8 requirements in section 245G.07, subdivision 2, paragraph (b), clause (8) (2), and must
102.9 be provided by a person who is qualified according to the requirements in section 245F.15,
102.10 subdivision 7.

102.11 Sec. 14. Minnesota Statutes 2024, section 245G.01, subdivision 13b, is amended to read:

102.12 Subd. 13b. **Guest speaker.** "Guest speaker" means an individual who is not an alcohol
102.13 and drug counselor qualified according to section 245G.11, subdivision 5; is not qualified
102.14 according to the commissioner's list of professionals under section 245G.07, subdivision 3;
102.15 clause (1); and who works under the direct observation of an alcohol and drug counselor to
102.16 present to clients on topics in which the guest speaker has expertise and that the license
102.17 holder has determined to be beneficial to a client's recovery. Tribally licensed programs
102.18 have autonomy to identify the qualifications of their guest speakers.

102.19 **EFFECTIVE DATE.** This section is effective July 1, 2026, or upon federal approval,
102.20 whichever is later. The commissioner of human services shall notify the revisor of statutes
102.21 when federal approval is obtained.

102.22 Sec. 15. Minnesota Statutes 2024, section 245G.01, is amended by adding a subdivision
102.23 to read:

102.24 Subd. 13d. **Individual counseling.** "Individual counseling" means professionally led
102.25 psychotherapeutic treatment for substance use disorders that is delivered in a one-to-one
102.26 setting or in a setting with the client and the client's family and other natural supports.

102.27 **EFFECTIVE DATE.** This section is effective July 1, 2026, or upon federal approval,
102.28 whichever is later. The commissioner of human services shall notify the revisor of statutes
102.29 when federal approval is obtained.

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149.15 Section 1. Minnesota Statutes 2024, section 245G.01, subdivision 13b, is amended to
149.16 read:

149.17 Subd. 13b. **Guest speaker.** (a) "Guest speaker" means an individual who is not an alcohol
149.18 and drug counselor qualified according to section 245G.11, subdivision 5; is not qualified
149.19 according to the commissioner's list of professionals under section 245G.07, subdivision
149.20 3; and who works under the direct observation of an alcohol and drug counselor to present
149.21 to clients on topics in which the guest speaker has expertise and that the license holder has
149.22 determined to be beneficial to a client's recovery.

149.23 (b) Tribally licensed programs have autonomy to identify the qualifications of their guest
149.24 speakers.

149.25 **EFFECTIVE DATE.** This section is effective July 1, 2026, or upon federal approval,
149.26 whichever is later. The commissioner of human services shall notify the revisor of statutes
149.27 when federal approval is obtained.

149.28 Sec. 2. Minnesota Statutes 2024, section 245G.01, is amended by adding a subdivision to
149.29 read:

149.30 Subd. 13d. **Individual counseling.** "Individual counseling" means professionally led
149.31 psychotherapeutic treatment for substance use disorders that is delivered in a one-to-one
149.32 setting or in a setting with the client and the client's family and other natural supports.

150.1 **EFFECTIVE DATE.** This section is effective July 1, 2026, or upon federal approval,
150.2 whichever is later. The commissioner of human services shall notify the revisor of statutes
150.3 when federal approval is obtained.

103.1 Sec. 16. Minnesota Statutes 2024, section 245G.01, is amended by adding a subdivision
103.2 to read:

103.3 Subd. 20f. **Psychoeducation.** "Psychoeducation" means the services described in section
103.4 245G.07, subdivision 1a, clause (2).

103.5 **EFFECTIVE DATE.** This section is effective July 1, 2026, or upon federal approval,
103.6 whichever is later. The commissioner of human services shall notify the revisor of statutes
103.7 when federal approval is obtained.

103.8 Sec. 17. Minnesota Statutes 2024, section 245G.01, is amended by adding a subdivision
103.9 to read:

103.10 Subd. 20g. **Psychosocial treatment services.** "Psychosocial treatment services" means
103.11 the services described in section 245G.07, subdivision 1a.

103.12 **EFFECTIVE DATE.** This section is effective July 1, 2026, or upon federal approval,
103.13 whichever is later. The commissioner of human services shall notify the revisor of statutes
103.14 when federal approval is obtained.

103.15 Sec. 18. Minnesota Statutes 2024, section 245G.01, is amended by adding a subdivision
103.16 to read:

103.17 Subd. 20h. **Recovery support services.** "Recovery support services" means the services
103.18 described in section 245G.07, subdivision 2a, paragraph (b), clause (1).

103.19 **EFFECTIVE DATE.** This section is effective July 1, 2026, or upon federal approval,
103.20 whichever is later. The commissioner of human services shall notify the revisor of statutes
103.21 when federal approval is obtained.

103.22 Sec. 19. Minnesota Statutes 2024, section 245G.01, is amended by adding a subdivision
103.23 to read:

103.24 Subd. 26a. **Treatment coordination.** "Treatment coordination" means the services
103.25 described in section 245G.07, subdivision 1b.

103.26 **EFFECTIVE DATE.** This section is effective July 1, 2026, or upon federal approval,
103.27 whichever is later. The commissioner of human services shall notify the revisor of statutes
103.28 when federal approval is obtained.

104.1 Sec. 20. Minnesota Statutes 2024, section 245G.02, subdivision 2, is amended to read:

104.2 Subd. 2. **Exemption from license requirement.** This chapter does not apply to a county
104.3 or recovery community organization that is providing a service for which the county or
104.4 recovery community organization is an eligible vendor under section 254B.05. This chapter
104.5 does not apply to an organization whose primary functions are information, referral,
104.6 diagnosis, case management, and assessment for the purposes of client placement, education,
104.7 support group services, or self-help programs. This chapter does not apply to the activities
104.8 of a licensed professional in private practice. A license holder providing the initial set of

150.4 Sec. 3. Minnesota Statutes 2024, section 245G.01, is amended by adding a subdivision to
150.5 read:

150.6 Subd. 20f. **Psychoeducation.** "Psychoeducation" means the services described in section
150.7 245G.07, subdivision 1a, clause (2).

150.8 **EFFECTIVE DATE.** This section is effective July 1, 2026, or upon federal approval,
150.9 whichever is later. The commissioner of human services shall notify the revisor of statutes
150.10 when federal approval is obtained.

150.11 Sec. 4. Minnesota Statutes 2024, section 245G.01, is amended by adding a subdivision to
150.12 read:

150.13 Subd. 20g. **Psychosocial treatment services.** "Psychosocial treatment services" means
150.14 the services described in section 245G.07, subdivision 1a.

150.15 **EFFECTIVE DATE.** This section is effective July 1, 2026, or upon federal approval,
150.16 whichever is later. The commissioner of human services shall notify the revisor of statutes
150.17 when federal approval is obtained.

150.18 Sec. 5. Minnesota Statutes 2024, section 245G.01, is amended by adding a subdivision to
150.19 read:

150.20 Subd. 20h. **Recovery support services.** "Recovery support services" means the services
150.21 described in section 245G.07, subdivision 2a, paragraph (b), clause (1).

150.22 **EFFECTIVE DATE.** This section is effective July 1, 2026, or upon federal approval,
150.23 whichever is later. The commissioner of human services shall notify the revisor of statutes
150.24 when federal approval is obtained.

150.25 Sec. 6. Minnesota Statutes 2024, section 245G.01, is amended by adding a subdivision to
150.26 read:

150.27 Subd. 26a. **Treatment coordination.** "Treatment coordination" means the services
150.28 described in section 245G.07, subdivision 1b.

151.1 **EFFECTIVE DATE.** This section is effective July 1, 2026, or upon federal approval,
151.2 whichever is later. The commissioner of human services shall notify the revisor of statutes
151.3 when federal approval is obtained.

151.4 Sec. 7. Minnesota Statutes 2024, section 245G.02, subdivision 2, is amended to read:

151.5 Subd. 2. **Exemption from license requirement.** This chapter does not apply to a county
151.6 or recovery community organization that is providing a service for which the county or
151.7 recovery community organization is an eligible vendor under section 254B.05. This chapter
151.8 does not apply to an organization whose primary functions are information, referral,
151.9 diagnosis, case management, and assessment for the purposes of client placement, education,
151.10 support group services, or self-help programs. This chapter does not apply to the activities
151.11 of a licensed professional in private practice. A license holder providing the initial set of

104.9 substance use disorder services allowable under section 254A.03, subdivision 3, paragraph
104.10 (c), to an individual referred to a licensed nonresidential substance use disorder treatment
104.11 program after a positive screen for alcohol or substance misuse is exempt from sections
104.12 245G.05; 245G.06, subdivisions 1, 1a, and 4; 245G.07, subdivisions 1, paragraph (a), clauses
104.13 ~~(2) to (4), and 2, clauses (1) to (7)~~ subdivision 1a, clause (2); and 245G.17.

104.14 EFFECTIVE DATE. This section is effective July 1, 2026, or upon federal approval,
104.15 whichever is later. The commissioner of human services shall notify the revisor of statutes
104.16 when federal approval is obtained.

151.12 substance use disorder services allowable under section 254A.03, subdivision 3, paragraph
151.13 (c), to an individual referred to a licensed nonresidential substance use disorder treatment
151.14 program after a positive screen for alcohol or substance misuse is exempt from sections
151.15 245G.05; 245G.06, subdivisions 1, 1a, and 4; 245G.07, subdivisions 1, paragraph (a), clauses
151.16 ~~(2) to (4), and 2, clauses (1) to (7)~~ subdivision 1a, clause (2); and 245G.17.

151.17 EFFECTIVE DATE. This section is effective July 1, 2026.

151.18 Sec. 8. Minnesota Statutes 2024, section 245G.05, subdivision 1, is amended to read:

151.19 Subdivision 1. **Comprehensive assessment.** (a) A comprehensive assessment of the
151.20 client's substance use disorder must be administered face-to-face by an alcohol and drug
151.21 counselor within five calendar days from the day of service initiation for a residential
151.22 program or by the end of the fifth day on which a treatment service is provided in a
151.23 nonresidential program. The number of days to complete the comprehensive assessment
151.24 excludes the day of service initiation.

151.25 (b) A comprehensive assessment must be administered by:

151.26 (1) an alcohol and drug counselor;

151.27 (2) a mental health professional who meets the qualifications under section 245I.04,
151.28 subdivision 2, practices within the scope of their professional licensure, and has training in
151.29 addiction, co-occurring disorders, and substance use disorder diagnosis and treatment
151.30 according to the requirements in section 245G.13, subdivision 2, paragraph (f);

152.1 (3) a clinical trainee who meets the qualifications under section 245I.04, subdivision 6,
152.2 practicing under the supervision of a mental health professional who meets the requirements
152.3 of clause (2); or

152.4 (4) an advanced practice registered nurse as defined in section 148.171, subdivision 3,
152.5 who practices within the scope of their professional licensure and has training in addiction,
152.6 co-occurring disorders, and substance use disorder diagnosis and treatment according to
152.7 the requirements in section 245G.13, subdivision 2, paragraph (f).

152.8 (c) If the comprehensive assessment is not completed within the required time frame,
152.9 the person-centered reason for the delay and the planned completion date must be documented
152.10 in the client's file. The comprehensive assessment is complete upon a qualified staff member's
152.11 dated signature. If the client received a comprehensive assessment that authorized the
152.12 treatment service, an alcohol and drug counselor or a staff member qualified under paragraph
152.13 (b) may use the comprehensive assessment for requirements of this subdivision but must
152.14 document a review of the comprehensive assessment and update the comprehensive
152.15 assessment as clinically necessary to ensure compliance with this subdivision within
152.16 applicable timelines. An alcohol and drug counselor or a staff member qualified under
152.17 paragraph (b) must sign and date the comprehensive assessment review and update.

104.17 Sec. 21. Minnesota Statutes 2024, section 245G.07, subdivision 1, is amended to read:

104.18 Subdivision 1. **Treatment service.** (a) A licensed ~~residential~~ treatment program must
104.19 offer the treatment services in ~~clauses (1) to (5)~~ subdivisions 1a and 1b and may offer the
104.20 treatment services in subdivision 2 to each client, unless clinically inappropriate and the
104.21 justifying clinical rationale is documented. ~~A nonresidential~~ The treatment program must
104.22 offer all treatment services in clauses (1) to (5) and document in the individual treatment
104.23 plan the specific services for which a client has an assessed need and the plan to provide
104.24 the services;.

104.25 (1) individual and group counseling to help the client identify and address needs related
104.26 to substance use and develop strategies to avoid harmful substance use after discharge and
104.27 to help the client obtain the services necessary to establish a lifestyle free of the harmful
104.28 effects of substance use disorder;

104.29 (2) client education strategies to avoid inappropriate substance use and health problems
104.30 related to substance use and the necessary lifestyle changes to regain and maintain health.
104.31 Client education must include information on tuberculosis education on a form approved
104.32 by the commissioner, the human immunodeficiency virus according to section 245A.19;
104.33 other sexually transmitted diseases, drug and alcohol use during pregnancy, and hepatitis;

105.1 (3) a service to help the client integrate gains made during treatment into daily living
105.2 and to reduce the client's reliance on a staff member for support;

105.3 (4) a service to address issues related to co-occurring disorders, including client education
105.4 on symptoms of mental illness, the possibility of comorbidity, and the need for continued
105.5 medication compliance while recovering from substance use disorder. A group must address
105.6 co-occurring disorders, as needed. When treatment for mental health problems is indicated,
105.7 the treatment must be integrated into the client's individual treatment plan; and

105.8 (5) treatment coordination provided one-to-one by an individual who meets the staff
105.9 qualifications in section 245G.11, subdivision 7. Treatment coordination services include:

105.10 (i) assistance in coordination with significant others to help in the treatment planning
105.11 process whenever possible;

105.12 (ii) assistance in coordination with and follow up for medical services as identified in
105.13 the treatment plan;

105.14 (iii) facilitation of referrals to substance use disorder services as indicated by a client's
105.15 medical provider, comprehensive assessment, or treatment plan;

105.16 (iv) facilitation of referrals to mental health services as identified by a client's
105.17 comprehensive assessment or treatment plan;

105.18 (v) assistance with referrals to economic assistance, social services, housing resources,
105.19 and prenatal care according to the client's needs;

152.18 Sec. 9. Minnesota Statutes 2024, section 245G.07, subdivision 1, is amended to read:

152.19 Subdivision 1. **Treatment service.** (a) A licensed ~~residential~~ treatment program must
152.20 offer the treatment services in ~~clauses (1) to (5)~~ subdivisions 1a and 1b and may offer the
152.21 treatment services in subdivision 2 to each client, unless clinically inappropriate and the
152.22 justifying clinical rationale is documented. ~~A nonresidential~~ The treatment program must
152.23 offer all treatment services in clauses (1) to (5) and document in the individual treatment
152.24 plan the specific services for which a client has an assessed need and the plan to provide
152.25 the services;.

152.26 (1) individual and group counseling to help the client identify and address needs related
152.27 to substance use and develop strategies to avoid harmful substance use after discharge and
152.28 to help the client obtain the services necessary to establish a lifestyle free of the harmful
152.29 effects of substance use disorder;

152.30 (2) client education strategies to avoid inappropriate substance use and health problems
152.31 related to substance use and the necessary lifestyle changes to regain and maintain health.
152.32 Client education must include information on tuberculosis education on a form approved
152.33 by the commissioner, the human immunodeficiency virus according to section 245A.19;
152.34 other sexually transmitted diseases, drug and alcohol use during pregnancy, and hepatitis;

153.1 (3) a service to help the client integrate gains made during treatment into daily living
153.2 and to reduce the client's reliance on a staff member for support;

153.3 (4) a service to address issues related to co-occurring disorders, including client education
153.4 on symptoms of mental illness, the possibility of comorbidity, and the need for continued
153.5 medication compliance while recovering from substance use disorder. A group must address
153.6 co-occurring disorders, as needed. When treatment for mental health problems is indicated,
153.7 the treatment must be integrated into the client's individual treatment plan; and

153.8 (5) treatment coordination provided one-to-one by an individual who meets the staff
153.9 qualifications in section 245G.11, subdivision 7. Treatment coordination services include:

153.10 (i) assistance in coordination with significant others to help in the treatment planning
153.11 process whenever possible;

153.12 (ii) assistance in coordination with and follow up for medical services as identified in
153.13 the treatment plan;

153.14 (iii) facilitation of referrals to substance use disorder services as indicated by a client's
153.15 medical provider, comprehensive assessment, or treatment plan;

153.16 (iv) facilitation of referrals to mental health services as identified by a client's
153.17 comprehensive assessment or treatment plan;

153.18 (v) assistance with referrals to economic assistance, social services, housing resources,
153.19 and prenatal care according to the client's needs;

105.20 ~~(vi) life skills advocacy and support accessing treatment follow-up, disease management,~~
105.21 ~~and education services, including referral and linkages to long-term services and supports~~
105.22 ~~as needed; and~~

105.23 ~~(vii) documentation of the provision of treatment coordination services in the client's~~
105.24 ~~file.~~

105.25 (b) A treatment service provided to a client must be provided according to the individual
105.26 treatment plan and must consider cultural differences and special needs of a client.

105.27 (c) A supportive service alone does not constitute a treatment service. Supportive services
105.28 include:

105.29 (1) milieu management or supervising or monitoring clients without also providing a
105.30 treatment service identified in subdivision 1a, 1b, or 2a;

105.31 (2) transporting clients;

106.1 (3) waiting with clients for appointments at social service agencies, court hearings, and
106.2 similar activities; and

106.3 (4) collecting urinalysis samples.

106.4 (d) A treatment service provided in a group setting must be provided in a cohesive
106.5 manner and setting that allows every client receiving the service to interact and receive the
106.6 same service at the same time.

106.7 EFFECTIVE DATE. This section is effective July 1, 2026, or upon federal approval,
106.8 whichever is later. The commissioner of human services shall notify the revisor of statutes
106.9 when federal approval is obtained.

106.10 Sec. 22. Minnesota Statutes 2024, section 245G.07, is amended by adding a subdivision
106.11 to read:

106.12 Subd. 1a. **Psychosocial treatment service.** Psychosocial treatment services must be
106.13 provided according to the hours identified in section 254B.19 for the ASAM level of care
106.14 provided to the client. A license holder must provide the following psychosocial treatment
106.15 services as a part of the client's individual treatment:

106.16 (1) counseling services that provide a client with professional assistance in managing
106.17 substance use disorder and co-occurring conditions, either individually or in a group setting.
106.18 Counseling must:

106.19 (i) use evidence-based techniques to help a client modify behavior, overcome obstacles,
106.20 and achieve and sustain recovery through techniques such as active listening, guidance,
106.21 discussion, feedback, and clarification;

153.20 ~~(vi) life skills advocacy and support accessing treatment follow-up, disease management,~~
153.21 ~~and education services, including referral and linkages to long-term services and supports~~
153.22 ~~as needed; and~~

153.23 ~~(vii) documentation of the provision of treatment coordination services in the client's~~
153.24 ~~file.~~

153.25 (b) A treatment service provided to a client must be provided according to the individual
153.26 treatment plan and must consider cultural differences and special needs of a client.

153.27 (c) A supportive service alone does not constitute a treatment service. Supportive services
153.28 include:

153.29 (1) milieu management or supervising or monitoring clients without also providing a
153.30 treatment service identified in subdivision 1a, 1b, or 2a;

153.31 (2) transporting clients;

154.1 (3) waiting with clients for appointments at social service agencies, court hearings, and
154.2 similar activities; and

154.3 (4) collecting urinalysis samples.

154.4 (d) A treatment service provided in a group setting must be provided in a cohesive
154.5 manner and setting that allows every client receiving the service to interact and receive the
154.6 same service at the same time.

154.7 EFFECTIVE DATE. This section is effective July 1, 2026, or upon federal approval,
154.8 whichever is later. The commissioner of human services shall notify the revisor of statutes
154.9 when federal approval is obtained.

154.10 Sec. 10. Minnesota Statutes 2024, section 245G.07, is amended by adding a subdivision
154.11 to read:

154.12 Subd. 1a. **Psychosocial treatment service.** Psychosocial treatment services must be
154.13 provided according to the hours identified in section 254B.19 for the ASAM level of care
154.14 provided to the client. A license holder must provide the following psychosocial treatment
154.15 services as a part of the client's individual treatment:

154.16 (1) counseling services that provide a client with professional assistance in managing
154.17 substance use disorder and co-occurring conditions, either individually or in a group setting.
154.18 Counseling must:

154.19 (i) use evidence-based techniques to help a client modify behavior, overcome obstacles,
154.20 and achieve and sustain recovery through techniques such as active listening, guidance,
154.21 discussion, feedback, and clarification;

106.22 (ii) help the client to identify and address needs related to substance use, develop
106.23 strategies to avoid harmful substance use, and establish a lifestyle free of the harmful effects
106.24 of substance use disorder; and

106.25 (iii) work to improve well-being and mental health, resolve or mitigate symptomatic
106.26 behaviors, beliefs, compulsions, thoughts, and emotions, and enhance relationships and
106.27 social skills, while addressing client-centered psychological and emotional needs; and

106.28 (2) psychoeducation services to provide a client with information about substance use
106.29 and co-occurring conditions, either individually or in a group setting. Psychoeducation
106.30 includes structured presentations, interactive discussions, and practical exercises to help
106.31 clients understand and manage their conditions effectively. Topics include but are not limited
106.32 to:

107.1 (i) the causes of substance use disorder and co-occurring disorders;

107.2 (ii) behavioral techniques that help a client change behaviors, thoughts, and feelings;

107.3 (iii) the importance of maintaining mental health, including understanding symptoms
107.4 of mental illness;

107.5 (iv) medications for addiction and psychiatric disorders and the importance of medication
107.6 adherence;

107.7 (v) the importance of maintaining physical health, health-related risk factors associated
107.8 with substance use disorder, and specific health education on tuberculosis, HIV, other
107.9 sexually transmitted diseases, drug and alcohol use during pregnancy, and hepatitis; and

107.10 (vi) harm-reduction strategies.

107.11 **EFFECTIVE DATE.** This section is effective July 1, 2026, or upon federal approval,
107.12 whichever is later. The commissioner of human services shall notify the revisor of statutes
107.13 when federal approval is obtained.

107.14 Sec. 23. Minnesota Statutes 2024, section 245G.07, is amended by adding a subdivision
107.15 to read:

107.16 Subd. 1b. **Treatment coordination.** (a) Treatment coordination must be provided to a
107.17 single client by an individual who meets the staff qualifications in section 245G.11,
107.18 subdivision 7. Treatment coordination services include:

107.19 (1) coordinating directly with others involved in the client's treatment and recovery,
107.20 including the referral source, family or natural supports, social services agencies, and external
107.21 care providers;

107.22 (2) providing clients with training and facilitating connections to community resources
107.23 that support recovery;

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154.22 (ii) help the client to identify and address needs related to substance use, develop
154.23 strategies to avoid harmful substance use, and establish a lifestyle free of the harmful effects
154.24 of substance use disorder; and

154.25 (iii) work to improve well-being and mental health, resolve or mitigate symptomatic
154.26 behaviors, beliefs, compulsions, thoughts, and emotions, and enhance relationships and
154.27 social skills, while addressing client-centered psychological and emotional needs; and

154.28 (2) psychoeducation services to provide a client with information about substance use
154.29 and co-occurring conditions, either individually or in a group setting. Psychoeducation
154.30 includes structured presentations, interactive discussions, and practical exercises to help
154.31 clients understand and manage their conditions effectively. Topics include but are not limited
154.32 to:

155.1 (i) the causes of substance use disorder and co-occurring disorders;

155.2 (ii) behavioral techniques that help a client change behaviors, thoughts, and feelings;

155.3 (iii) the importance of maintaining mental health, including understanding symptoms
155.4 of mental illness;

155.5 (iv) medications for addiction and psychiatric disorders and the importance of medication
155.6 adherence;

155.7 (v) the importance of maintaining physical health, health-related risk factors associated
155.8 with substance use disorder, and specific health education on tuberculosis, HIV, other
155.9 sexually transmitted diseases, drug and alcohol use during pregnancy, and hepatitis; and

155.10 (vi) harm-reduction strategies.

155.11 **EFFECTIVE DATE.** This section is effective July 1, 2026, or upon federal approval,
155.12 whichever is later. The commissioner of human services shall notify the revisor of statutes
155.13 when federal approval is obtained.

155.14 Sec. 11. Minnesota Statutes 2024, section 245G.07, is amended by adding a subdivision
155.15 to read:

155.16 Subd. 1b. **Treatment coordination.** (a) Treatment coordination must be provided to a
155.17 single client by an individual who meets the staff qualifications in section 245G.11,
155.18 subdivision 7. Treatment coordination services include:

155.19 (1) coordinating directly with others involved in the client's treatment and recovery,
155.20 including the referral source, family or natural supports, social services agencies, and external
155.21 care providers;

155.22 (2) providing clients with training and facilitating connections to community resources
155.23 that support recovery;

107.24 (3) assisting clients in obtaining necessary resources and services such as financial
107.25 assistance, housing, food, clothing, medical care, education, harm reduction services,
107.26 vocational support, and recreational services that promote recovery;

107.27 (4) assisting clients in navigating economic assistance and Minnesota health care
107.28 programs under chapters 256B and 256L;

107.29 (5) helping clients connect and engage with self-help support groups and expand social
107.30 support networks with family, friends, and organizations; and

108.1 (6) assisting clients in transitioning between levels of care, including providing direct
108.2 connections to ensure continuity of care.

108.3 (b) Treatment coordination does not include coordinating services or communicating
108.4 with staff members within the licensed program.

108.5 (c) Treatment coordination may be provided in a setting with the individual client and
108.6 others involved in the client's treatment and recovery.

108.7 **EFFECTIVE DATE.** This section is effective July 1, 2026, or upon federal approval,
108.8 whichever is later. The commissioner of human services shall notify the revisor of statutes
108.9 when federal approval is obtained.

108.10 Sec. 24. Minnesota Statutes 2024, section 245G.07, is amended by adding a subdivision
108.11 to read:

108.12 Subd. 2a. **Ancillary treatment service.** (a) A license holder may provide ancillary
108.13 services in addition to the hours of psychosocial treatment services identified in section
108.14 254B.19 for the ASAM level of care provided to the client.

108.15 (b) A license holder may provide the following ancillary treatment services as a part of
108.16 the client's individual treatment:

108.17 (1) recovery support services provided individually or in a group setting, that include:

108.18 (i) supporting clients in restoring daily living skills, such as health and health care
108.19 navigation and self-care to enhance personal well-being;

108.20 (ii) providing resources and assistance to help clients restore life skills, including effective
108.21 parenting, financial management, pro-social behavior, education, employment, and nutrition;

108.22 (iii) assisting clients in restoring daily functioning and routines affected by substance
108.23 use and supporting them in developing skills for successful community integration; and

108.24 (iv) helping clients respond to or avoid triggers that threaten their community stability,
108.25 assisting the client in identifying potential crises and developing a plan to address them,
108.26 and providing support to restore the client's stability and functioning; and

155.24 (3) assisting clients in obtaining necessary resources and services such as financial
155.25 assistance, housing, food, clothing, medical care, education, harm reduction services,
155.26 vocational support, and recreational services that promote recovery;

155.27 (4) helping clients connect and engage with self-help support groups and expand social
155.28 support networks with family, friends, and organizations; and

155.29 (5) assisting clients in transitioning between levels of care, including providing direct
155.30 connections to ensure continuity of care.

156.1 (b) Treatment coordination does not include coordinating services or communicating
156.2 with staff members within the licensed program.

156.3 (c) Treatment coordination may be provided in a setting with the individual client and
156.4 others involved in the client's treatment and recovery.

156.5 **EFFECTIVE DATE.** This section is effective July 1, 2026, or upon federal approval,
156.6 whichever is later. The commissioner of human services shall notify the revisor of statutes
156.7 when federal approval is obtained.

156.8 Sec. 12. Minnesota Statutes 2024, section 245G.07, is amended by adding a subdivision
156.9 to read:

156.10 Subd. 2a. **Ancillary treatment service.** (a) A license holder may provide ancillary
156.11 services in addition to the hours of psychosocial treatment services identified in section
156.12 254B.19 for the ASAM level of care provided to the client.

156.13 (b) A license holder may provide the following ancillary treatment services as a part of
156.14 the client's individual treatment:

156.15 (1) recovery support services provided individually or in a group setting, that include:

156.16 (i) supporting clients in restoring daily living skills, such as health and health care
156.17 navigation and self-care to enhance personal well-being;

156.18 (ii) providing resources and assistance to help clients restore life skills, including effective
156.19 parenting, financial management, pro-social behavior, education, employment, and nutrition;

156.20 (iii) assisting clients in restoring daily functioning and routines affected by substance
156.21 use and supporting them in developing skills for successful community integration; and

156.22 (iv) helping clients respond to or avoid triggers that threaten their community stability,
156.23 assisting the client in identifying potential crises and developing a plan to address them,
156.24 and providing support to restore the client's stability and functioning; and

108.27 (2) peer recovery support services provided according to sections 254B.05, subdivision
108.28 5, and 254B.052.

108.29 **EFFECTIVE DATE.** This section is effective July 1, 2026, or upon federal approval,
108.30 whichever is later. The commissioner of human services shall notify the revisor of statutes
108.31 when federal approval is obtained.

109.1 Sec. 25. Minnesota Statutes 2024, section 245G.07, subdivision 3, is amended to read:

109.2 Subd. 3. ~~Counselors Treatment service providers.~~ (a) All treatment services, ~~except~~
109.3 ~~peer recovery support services and treatment coordination,~~ must be provided by an alcohol
109.4 ~~and drug counselor qualified according to section 245G.11, subdivision 5, unless the~~
109.5 individual providing the service is specifically qualified according to the accepted credential
109.6 required to provide the service. ~~The commissioner shall maintain a current list of~~
109.7 ~~professionals qualified to provide treatment services.~~

109.8 (b) Psychosocial treatment services must be provided by an alcohol and drug counselor
109.9 qualified according to section 245G.11, subdivision 5, unless the individual providing the
109.10 service is specifically qualified according to the accepted credential required to provide the
109.11 service. The commissioner shall maintain a current list of professionals qualified to provide
109.12 psychosocial treatment services.

109.13 (c) Treatment coordination must be provided by a treatment coordinator qualified
109.14 according to section 245G.11, subdivision 7.

109.15 (d) Recovery support services must be provided by a behavioral health practitioner
109.16 qualified according to section 245G.11, subdivision 12.

109.17 (e) Peer recovery support services must be provided by a recovery peer qualified
109.18 according to section 245I.04, subdivision 18.

109.19 **EFFECTIVE DATE.** This section is effective July 1, 2026, or upon federal approval,
109.20 whichever is later. The commissioner of human services shall notify the revisor of statutes
109.21 when federal approval is obtained.

109.22 Sec. 26. Minnesota Statutes 2024, section 245G.07, subdivision 4, is amended to read:

109.23 Subd. 4. **Location of service provision.** (a) The license holder must provide all treatment
109.24 services a client receives at one of the license holder's substance use disorder treatment
109.25 licensed locations or at a location allowed under paragraphs (b) to (f). If the services are
109.26 provided at the locations in paragraphs (b) to (d), the license holder must document in the
109.27 client record the location services were provided.

109.28 (b) The license holder may provide nonresidential individual treatment services at a
109.29 client's home or place of residence.

109.30 (c) If the license holder provides treatment services by telehealth, the services must be
109.31 provided according to this paragraph:

156.25 (2) peer recovery support services provided according to sections 254B.05, subdivision
156.26 5, and 254B.052.

156.27 **EFFECTIVE DATE.** This section is effective July 1, 2026, or upon federal approval,
156.28 whichever is later. The commissioner of human services shall notify the revisor of statutes
156.29 when federal approval is obtained.

157.1 Sec. 13. Minnesota Statutes 2024, section 245G.07, subdivision 3, is amended to read:

157.2 Subd. 3. ~~Counselors Treatment service providers.~~ (a) All treatment services, ~~except~~
157.3 ~~peer recovery support services and treatment coordination,~~ must be provided by an alcohol
157.4 ~~and drug counselor qualified according to section 245G.11, subdivision 5, unless the~~
157.5 individual providing the service is specifically qualified according to the accepted credential
157.6 required to provide the service. ~~The commissioner shall maintain a current list of~~
157.7 ~~professionals qualified to provide treatment services.~~

157.8 (b) Psychosocial treatment services must be provided by an alcohol and drug counselor
157.9 qualified according to section 245G.11, subdivision 5, unless the individual providing the
157.10 service is specifically qualified according to the accepted credential required to provide the
157.11 service. The commissioner shall maintain a current list of professionals qualified to provide
157.12 psychosocial treatment services.

157.13 (c) Treatment coordination must be provided by a treatment coordinator qualified
157.14 according to section 245G.11, subdivision 7.

157.15 (d) Recovery support services must be provided by a behavioral health practitioner
157.16 qualified according to section 245G.11, subdivision 12.

157.17 (e) Peer recovery support services must be provided by a recovery peer qualified
157.18 according to section 245I.04, subdivision 18.

157.19 **EFFECTIVE DATE.** This section is effective July 1, 2026, or upon federal approval,
157.20 whichever is later. The commissioner of human services shall notify the revisor of statutes
157.21 when federal approval is obtained.

157.22 Sec. 14. Minnesota Statutes 2024, section 245G.07, subdivision 4, is amended to read:

157.23 Subd. 4. **Location of service provision.** (a) The license holder must provide all treatment
157.24 services a client receives at one of the license holder's substance use disorder treatment
157.25 licensed locations or at a location allowed under paragraphs (b) to (f). If the services are
157.26 provided at the locations in paragraphs (b) to (d), the license holder must document in the
157.27 client record the location services were provided.

157.28 (b) The license holder may provide nonresidential individual treatment services at a
157.29 client's home or place of residence.

157.30 (c) If the license holder provides treatment services by telehealth, the services must be
157.31 provided according to this paragraph:

110.1 (1) the license holder must maintain a licensed physical location in Minnesota where
110.2 the license holder must offer all treatment services in subdivision 1, paragraph (a), clauses
110.3 ~~(1) to (4)~~, 1a physically in-person to each client;

110.4 (2) the license holder must meet all requirements for the provision of telehealth in sections
110.5 254B.05, subdivision 5, paragraph (f), and 256B.0625, subdivision 3b. The license holder
110.6 must document all items in section 256B.0625, subdivision 3b, paragraph (c), for each client
110.7 receiving services by telehealth, regardless of payment type or whether the client is a medical
110.8 assistance enrollee;

110.9 (3) the license holder may provide treatment services by telehealth to clients individually;

110.10 (4) the license holder may provide treatment services by telehealth to a group of clients
110.11 that are each in a separate physical location;

110.12 (5) the license holder must not provide treatment services remotely by telehealth to a
110.13 group of clients meeting together in person, unless permitted under clause (7);

110.14 (6) clients and staff may join an in-person group by telehealth if a staff member qualified
110.15 to provide the treatment service is physically present with the group of clients meeting
110.16 together in person; and

110.17 (7) the qualified professional providing a residential group treatment service by telehealth
110.18 must be physically present on-site at the licensed residential location while the service is
110.19 being provided. If weather conditions or short-term illness prohibit a qualified professional
110.20 from traveling to the residential program and another qualified professional is not available
110.21 to provide the service, a qualified professional may provide a residential group treatment
110.22 service by telehealth from a location away from the licensed residential location. In such
110.23 circumstances, the license holder must ensure that a qualified professional does not provide
110.24 a residential group treatment service by telehealth from a location away from the licensed
110.25 residential location for more than one day at a time, must ensure that a staff person who
110.26 qualifies as a paraprofessional is physically present with the group of clients, and must
110.27 document the reason for providing the remote telehealth service in the records of clients
110.28 receiving the service. The license holder must document the dates that residential group
110.29 treatment services were provided by telehealth from a location away from the licensed
110.30 residential location in a central log and must provide the log to the commissioner upon
110.31 request.

110.32 (d) The license holder may provide the ~~additional ancillary~~ treatment services under
110.33 subdivision 2, ~~clauses (2) to (6) and (8)~~, 2a away from the licensed location at a suitable
110.34 location appropriate to the treatment service.

111.1 (e) Upon written approval from the commissioner for each satellite location, the license
111.2 holder may provide nonresidential treatment services at satellite locations that are in a
111.3 school, jail, or nursing home. A satellite location may only provide services to students of
111.4 the school, inmates of the jail, or residents of the nursing home. Schools, jails, and nursing
111.5 homes are exempt from the licensing requirements in section 245A.04, subdivision 2a, to

158.1 (1) the license holder must maintain a licensed physical location in Minnesota where
158.2 the license holder must offer all treatment services in subdivision 1, paragraph (a), clauses
158.3 ~~(1) to (4)~~, 1a physically in-person to each client;

158.4 (2) the license holder must meet all requirements for the provision of telehealth in sections
158.5 254B.05, subdivision 5, paragraph (f), and 256B.0625, subdivision 3b. The license holder
158.6 must document all items in section 256B.0625, subdivision 3b, paragraph (c), for each client
158.7 receiving services by telehealth, regardless of payment type or whether the client is a medical
158.8 assistance enrollee;

158.9 (3) the license holder may provide treatment services by telehealth to clients individually;

158.10 (4) the license holder may provide treatment services by telehealth to a group of clients
158.11 that are each in a separate physical location;

158.12 (5) the license holder must not provide treatment services remotely by telehealth to a
158.13 group of clients meeting together in person, unless permitted under clause (7);

158.14 (6) clients and staff may join an in-person group by telehealth if a staff member qualified
158.15 to provide the treatment service is physically present with the group of clients meeting
158.16 together in person; and

158.17 (7) the qualified professional providing a residential group treatment service by telehealth
158.18 must be physically present on-site at the licensed residential location while the service is
158.19 being provided. If weather conditions or short-term illness prohibit a qualified professional
158.20 from traveling to the residential program and another qualified professional is not available
158.21 to provide the service, a qualified professional may provide a residential group treatment
158.22 service by telehealth from a location away from the licensed residential location. In such
158.23 circumstances, the license holder must ensure that a qualified professional does not provide
158.24 a residential group treatment service by telehealth from a location away from the licensed
158.25 residential location for more than one day at a time, must ensure that a staff person who
158.26 qualifies as a paraprofessional is physically present with the group of clients, and must
158.27 document the reason for providing the remote telehealth service in the records of clients
158.28 receiving the service. The license holder must document the dates that residential group
158.29 treatment services were provided by telehealth from a location away from the licensed
158.30 residential location in a central log and must provide the log to the commissioner upon
158.31 request.

158.32 (d) The license holder may provide the ~~additional ancillary~~ treatment services under
158.33 subdivision 2, ~~clauses (2) to (6) and (8)~~, 2a away from the licensed location at a suitable
158.34 location appropriate to the treatment service.

159.1 (e) Upon written approval from the commissioner for each satellite location, the license
159.2 holder may provide nonresidential treatment services at satellite locations that are in a
159.3 school, jail, or nursing home. A satellite location may only provide services to students of
159.4 the school, inmates of the jail, or residents of the nursing home. Schools, jails, and nursing
159.5 homes are exempt from the licensing requirements in section 245A.04, subdivision 2a, to

111.6 document compliance with building codes, fire and safety codes, health rules, and zoning
111.7 ordinances.

111.8 (f) The commissioner may approve other suitable locations as satellite locations for
111.9 nonresidential treatment services. The commissioner may require satellite locations under
111.10 this paragraph to meet all applicable licensing requirements. The license holder may not
111.11 have more than two satellite locations per license under this paragraph.

111.12 (g) The license holder must provide the commissioner access to all files, documentation,
111.13 staff persons, and any other information the commissioner requires at the main licensed
111.14 location for all clients served at any location under paragraphs (b) to (f).

111.15 (h) Notwithstanding sections 245A.65, subdivision 2, and 626.557, subdivision 14, a
111.16 program abuse prevention plan is not required for satellite or other locations under paragraphs
111.17 (b) to (e). An individual abuse prevention plan is still required for any client that is a
111.18 vulnerable adult as defined in section 626.5572, subdivision 21.

111.19 EFFECTIVE DATE. This section is effective July 1, 2026, or upon federal approval,
111.20 whichever is later. The commissioner of human services shall notify the revisor of statutes
111.21 when federal approval is obtained.

111.22 Sec. 27. Minnesota Statutes 2024, section 245G.11, subdivision 6, is amended to read:

111.23 Subd. 6. **Paraprofessionals.** A paraprofessional must have knowledge of client rights,
111.24 according to section 148F.165, and staff member responsibilities. A paraprofessional may
111.25 not make decisions to admit, transfer, or discharge a client but may perform tasks related
111.26 to intake and orientation. A paraprofessional may be the responsible for the delivery of
111.27 treatment service staff member according to section 245G.10, subdivision 3. A
111.28 paraprofessional must not provide a treatment service unless qualified to do so according
111.29 to section 245G.07, subdivision 3.

111.30 EFFECTIVE DATE. This section is effective July 1, 2026, or upon federal approval,
111.31 whichever is later. The commissioner of human services shall notify the revisor of statutes
111.32 when federal approval is obtained.

112.1 Sec. 28. Minnesota Statutes 2024, section 245G.11, is amended by adding a subdivision
112.2 to read:

112.3 Subd. 12. **Behavioral health practitioners.** (a) A behavioral health practitioner must
112.4 meet the qualifications in section 245I.04, subdivision 4.

112.5 (b) A behavioral health practitioner working within a substance use disorder treatment
112.6 program licensed under this chapter has the following scope of practice:

112.7 (1) a behavioral health practitioner may provide clients with recovery support services,
112.8 as defined in section 245G.07, subdivision 2a, paragraph (b), clause (1); and

159.6 document compliance with building codes, fire and safety codes, health rules, and zoning
159.7 ordinances.

159.8 (f) The commissioner may approve other suitable locations as satellite locations for
159.9 nonresidential treatment services. The commissioner may require satellite locations under
159.10 this paragraph to meet all applicable licensing requirements. The license holder may not
159.11 have more than two satellite locations per license under this paragraph.

159.12 (g) The license holder must provide the commissioner access to all files, documentation,
159.13 staff persons, and any other information the commissioner requires at the main licensed
159.14 location for all clients served at any location under paragraphs (b) to (f).

159.15 (h) Notwithstanding sections 245A.65, subdivision 2, and 626.557, subdivision 14, a
159.16 program abuse prevention plan is not required for satellite or other locations under paragraphs
159.17 (b) to (e). An individual abuse prevention plan is still required for any client that is a
159.18 vulnerable adult as defined in section 626.5572, subdivision 21.

159.19 EFFECTIVE DATE. This section is effective July 1, 2026, or upon federal approval,
159.20 whichever is later. The commissioner of human services shall notify the revisor of statutes
159.21 when federal approval is obtained.

159.22 Sec. 15. Minnesota Statutes 2024, section 245G.11, subdivision 6, is amended to read:

159.23 Subd. 6. **Paraprofessionals.** A paraprofessional must have knowledge of client rights,
159.24 according to section 148F.165, and staff member responsibilities. A paraprofessional may
159.25 not make decisions to admit, transfer, or discharge a client but may perform tasks related
159.26 to intake and orientation. A paraprofessional may be the responsible for the delivery of
159.27 treatment service staff member according to section 245G.10, subdivision 3. A
159.28 paraprofessional must not provide a treatment service unless qualified to do so according
159.29 to section 245G.07, subdivision 3.

160.1 Sec. 16. Minnesota Statutes 2024, section 245G.11, is amended by adding a subdivision
160.2 to read:

160.3 Subd. 12. **Behavioral health practitioners.** (a) A behavioral health practitioner must
160.4 meet the mental health practitioner qualifications in section 245I.04, subdivision 4.

160.5 (b) A behavioral health practitioner working within a substance use disorder treatment
160.6 program licensed under this chapter has the following scope of practice:

160.7 (1) A behavioral health practitioner may provide clients with recovery support services,
160.8 as defined in section 245G.07, subdivision 2a, paragraph (b), clause (1); and

112.9 (2) a behavioral health practitioner must not provide treatment supervision to other staff
112.10 persons.

112.11 (c) A behavioral health practitioner working within a substance use disorder treatment
112.12 program licensed under this chapter must receive at least one hour of supervision per month
112.13 on individual service delivery from an alcohol and drug counselor or a mental health
112.14 professional who has substance use treatment and assessments within the scope of their
112.15 practice.

112.16 EFFECTIVE DATE. This section is effective July 1, 2026, or upon federal approval,
112.17 whichever is later. The commissioner of human services shall notify the revisor of statutes
112.18 when federal approval is obtained.

112.19 Sec. 29. Minnesota Statutes 2024, section 245G.22, subdivision 11, is amended to read:

112.20 Subd. 11. **Waiting list.** An opioid treatment program must have a waiting list system.
112.21 If the person seeking admission cannot be admitted within 14 days of the date of application,
112.22 each person seeking admission must be placed on the waiting list, unless the person seeking
112.23 admission is assessed by the program and found ineligible for admission according to this
112.24 chapter and Code of Federal Regulations, title 42, part 1, subchapter A, section 8.12 (c),
112.25 and title 45, parts 160 to 164. The waiting list must assign a unique client identifier for each
112.26 person seeking treatment while awaiting admission. A person seeking admission on a waiting
112.27 list who receives no services under section 245G.07, subdivision 1 1a or 1b, must not be
112.28 considered a client as defined in section 245G.01, subdivision 9.

112.29 EFFECTIVE DATE. This section is effective July 1, 2026, or upon federal approval,
112.30 whichever is later. The commissioner of human services shall notify the revisor of statutes
112.31 when federal approval is obtained.

113.1 Sec. 30. Minnesota Statutes 2024, section 245G.22, subdivision 15, is amended to read:

113.2 Subd. 15. **Nonmedication treatment services; documentation.** (a) The program must
113.3 offer at least ~~50 consecutive minutes~~ four units of individual or group therapy treatment
113.4 services as defined in section 245G.07, subdivision 1, ~~paragraph (a) 1a~~, clause (1), per week,
113.5 for the first ten weeks following the day of service initiation, and at least ~~50 consecutive~~
113.6 ~~minutes~~ four units per month thereafter. ~~As clinically appropriate, the program may offer~~
113.7 ~~these services cumulatively and not consecutively in increments of no less than 15 minutes~~
113.8 ~~over the required time period, and for a total of 60 minutes of treatment services over the~~
113.9 ~~time period, and must document the reason for providing services cumulatively in the client's~~
113.10 ~~record.~~ The program may offer additional levels of service when deemed clinically necessary.

113.11 (b) Notwithstanding the requirements of comprehensive assessments in section 245G.05,
113.12 the assessment must be completed within 21 days from the day of service initiation.

160.9 (2) a behavioral health practitioner must not provide treatment supervision to other staff
160.10 persons.

160.11 (c) A behavioral health practitioner working within a substance use disorder treatment
160.12 program licensed under this chapter must receive at least one hour of supervision per month
160.13 on individual service delivery from an alcohol and drug counselor or a mental health
160.14 professional who has substance use treatment and assessments within the scope of their
160.15 practice.

160.16 EFFECTIVE DATE. This section is effective July 1, 2026, or upon federal approval,
160.17 whichever is later. The commissioner of human services shall notify the revisor of statutes
160.18 when federal approval is obtained.

160.19 Sec. 17. Minnesota Statutes 2024, section 245G.22, subdivision 11, is amended to read:

160.20 Subd. 11. **Waiting list.** An opioid treatment program must have a waiting list system.
160.21 If the person seeking admission cannot be admitted within 14 days of the date of application,
160.22 each person seeking admission must be placed on the waiting list, unless the person seeking
160.23 admission is assessed by the program and found ineligible for admission according to this
160.24 chapter and Code of Federal Regulations, title 42, part 1, subchapter A, section 8.12 (c),
160.25 and title 45, parts 160 to 164. The waiting list must assign a unique client identifier for each
160.26 person seeking treatment while awaiting admission. A person seeking admission on a waiting
160.27 list who receives no services under section 245G.07, subdivision 1 1a or 1b, must not be
160.28 considered a client as defined in section 245G.01, subdivision 9.

160.29 EFFECTIVE DATE. This section is effective July 1, 2026, or upon federal approval,
160.30 whichever is later. The commissioner of human services shall notify the revisor of statutes
160.31 when federal approval is obtained.

161.1 Sec. 18. Minnesota Statutes 2024, section 245G.22, subdivision 15, is amended to read:

161.2 Subd. 15. **Nonmedication treatment services; documentation.** (a) The program must
161.3 offer at least ~~50 consecutive minutes~~ four units of individual or group therapy treatment
161.4 services as defined in section 245G.07, subdivision 1, ~~paragraph (a) 1a~~, clause (1), per week,
161.5 for the first ten weeks following the day of service initiation, and at least ~~50 consecutive~~
161.6 ~~minutes~~ one unit per month thereafter. ~~As clinically appropriate, the program may offer~~
161.7 ~~these services cumulatively and not consecutively in increments of no less than 15 minutes~~
161.8 ~~over the required time period, and for a total of 60 minutes of treatment services over the~~
161.9 ~~time period, and must document the reason for providing services cumulatively in the client's~~
161.10 ~~record.~~ The program may offer additional levels of service when deemed clinically necessary.

161.11 (b) Notwithstanding the requirements of comprehensive assessments in section 245G.05,
161.12 the assessment must be completed within 21 days from the day of service initiation.

113.13 **EFFECTIVE DATE.** This section is effective July 1, 2026, or upon federal approval,
113.14 whichever is later. The commissioner of human services shall notify the revisor of statutes
113.15 when federal approval is obtained.

113.16 Sec. 31. Minnesota Statutes 2024, section 254A.19, subdivision 4, is amended to read:

113.17 Subd. 4. **Civil commitments.** For the purposes of determining level of care, a
113.18 comprehensive assessment does not need to be completed for an individual being committed
113.19 as a chemically dependent person, as defined in section 253B.02, and for the duration of a
113.20 civil commitment under section 253B.09 or 253B.095 in order for a county the individual
113.21 to access be eligible for the behavioral health fund under section 254B.04. The county
113.22 commissioner must determine if the individual meets the financial eligibility requirements
113.23 for the behavioral health fund under section 254B.04.

113.24 **EFFECTIVE DATE.** This section is effective July 1, 2026.

113.25 Sec. 32. Minnesota Statutes 2024, section 254B.01, subdivision 10, is amended to read:

113.26 Subd. 10. ~~Skilled Psychosocial treatment services.~~ "Skilled Psychosocial treatment
113.27 services" includes the treatment services described in section 245G.07, subdivisions 1,
113.28 paragraph (a), clauses (1) to (4), and 2, clauses (1) to (6). Skilled subdivision 1a. Psychosocial
113.29 treatment services must be provided by qualified professionals as identified in section
113.30 245G.07, subdivision 3, paragraph (b).

114.1 **EFFECTIVE DATE.** This section is effective July 1, 2026, or upon federal approval,
114.2 whichever is later. The commissioner of human services shall notify the revisor of statutes
114.3 when federal approval is obtained.

114.4 Sec. 33. Minnesota Statutes 2024, section 254B.01, subdivision 11, is amended to read:

114.5 Subd. 11. ~~Sober home Recovery residence.~~ A sober home recovery residence is a
114.6 cooperative living residence, a room and board residence, an apartment, or any other living
114.7 accommodation that:

114.8 (1) provides temporary housing to persons with substance use disorders;

114.9 (2) stipulates that residents must abstain from using alcohol or other illicit drugs or
114.10 substances not prescribed by a physician;

114.11 (3) charges a fee for living there;

114.12 (4) does not provide counseling or treatment services to residents;

114.13 (5) promotes sustained recovery from substance use disorders; and

114.14 (6) follows the sober living guidelines published by the federal Substance Abuse and
114.15 Mental Health Services Administration.

114.16 **EFFECTIVE DATE.** This section is effective January 1, 2027.

161.13 **EFFECTIVE DATE.** This section is effective July 1, 2026, or upon federal approval,
161.14 whichever is later. The commissioner of human services shall notify the revisor of statutes
161.15 when federal approval is obtained.

161.16 Sec. 19. Minnesota Statutes 2024, section 254B.01, subdivision 10, is amended to read:

161.17 Subd. 10. ~~Skilled Psychosocial treatment services.~~ "Skilled Psychosocial treatment
161.18 services" includes the treatment services described in section 245G.07, subdivisions 1,
161.19 paragraph (a), clauses (1) to (4), and 2, clauses (1) to (6). Skilled subdivision 1a. Psychosocial
161.20 treatment services must be provided by qualified professionals as identified in section
161.21 245G.07, subdivision 3, paragraph (b).

161.22 **EFFECTIVE DATE.** This section is effective July 1, 2026, or upon federal approval,
161.23 whichever is later. The commissioner of human services shall notify the revisor of statutes
161.24 when federal approval is obtained.

114.17 Sec. 34. Minnesota Statutes 2024, section 254B.02, subdivision 5, is amended to read:

114.18 Subd. 5. **Local agency Tribal allocation.** The commissioner may make payments to
114.19 ~~local agencies~~ Tribal Nation servicing agencies from money allocated under this section to
114.20 support individuals with substance use disorders and determine eligibility for behavioral
114.21 health fund payments. The payment must not be less than 133 percent of the ~~local agency~~
114.22 Tribal Nations payment for the fiscal year ending June 30, 2009, adjusted in proportion to
114.23 the statewide change in the appropriation for this chapter.

114.24 **EFFECTIVE DATE.** This section is effective July 1, 2026.

114.25 Sec. 35. Minnesota Statutes 2024, section 254B.03, subdivision 1, is amended to read:

114.26 Subdivision 1. ~~Local agency duties~~ **Financial eligibility determinations.** (a) Every
114.27 ~~local agency~~ The commissioner of human services or Tribal Nation servicing agencies must
114.28 determine financial eligibility for substance use disorder services and provide substance
114.29 use disorder services to persons residing within its jurisdiction who meet criteria established
114.30 by the commissioner. Substance use disorder money must be administered by the local
115.1 agencies according to law and rules adopted by the commissioner under sections 14.001 to
115.2 14.69.

115.3 (b) In order to contain costs, the commissioner of human services shall select eligible
115.4 vendors of substance use disorder services who can provide economical and appropriate
115.5 treatment. ~~Unless the local agency is a social services department directly administered by~~
115.6 ~~a county or human services board, the local agency shall not be an eligible vendor under~~
115.7 ~~section 254B.05.~~ The commissioner may approve proposals from county boards to provide
115.8 services in an economical manner or to control utilization, with safeguards to ensure that
115.9 necessary services are provided. If a county implements a demonstration or experimental
115.10 medical services funding plan, the commissioner shall transfer the money as appropriate.

115.11 (c) An individual may choose to obtain a comprehensive assessment as provided in
115.12 section 245G.05. Individuals obtaining a comprehensive assessment may access any enrolled
115.13 provider that is licensed to provide the level of service authorized pursuant to section
115.14 254A.19, subdivision 3. If the individual is enrolled in a prepaid health plan, the individual
115.15 must comply with any provider network requirements or limitations.

115.16 (d) ~~Beginning July 1, 2022, local agencies shall not make placement location~~
115.17 ~~determinations.~~

115.18 **EFFECTIVE DATE.** This section is effective July 1, 2026.

115.19 Sec. 36. Minnesota Statutes 2024, section 254B.03, subdivision 3, is amended to read:

115.20 Subd. 3. ~~Local agencies~~ **Counties to pay state for county share.** ~~Local agencies~~
115.21 ~~Counties~~ shall pay the state for the county share of the services authorized by the ~~local~~
115.22 ~~agency~~ commissioner, except when the payment is made according to section 254B.09,
115.23 subdivision 8.

115.24 **EFFECTIVE DATE.** This section is effective July 1, 2026.

115.25 Sec. 37. Minnesota Statutes 2024, section 254B.03, subdivision 4, is amended to read:

115.26 Subd. 4. **Division of costs.** (a) Except for services provided by a county under section
115.27 254B.09, subdivision 1, or services provided under section 256B.69, the county shall, out
115.28 of local money, pay the state for ~~22.95~~ 50 percent of the cost of substance use disorder
115.29 services, except for ~~those~~ individuals living in carceral settings. The county shall pay the
115.30 state 22.95 percent of the cost of substance use disorder services for individuals in carceral
115.31 settings. Services provided to persons enrolled in medical assistance under chapter 256B
115.32 and room and board services under section 254B.05, subdivision 5, paragraph (b), are
116.1 exempted from county contributions. Counties may use the indigent hospitalization levy
116.2 for treatment and hospital payments made under this section.

116.3 (b) ~~22.95~~ 50 percent of any state collections from private or third-party pay, less 15
116.4 percent for the cost of payment and collections, must be distributed to the county that paid
116.5 for a portion of the treatment under this section.

116.6 **EFFECTIVE DATE.** This section is effective January 1, 2026.

116.7 Sec. 38. Minnesota Statutes 2024, section 254B.04, subdivision 1a, is amended to read:

116.8 Subd. 1a. **Client eligibility.** (a) Persons eligible for benefits under Code of Federal
116.9 Regulations, title 25, part 20, who meet the income standards of section 256B.056,
116.10 subdivision 4, and are not enrolled in medical assistance, are entitled to behavioral health
116.11 fund services. State money appropriated for this paragraph must be placed in a separate
116.12 account established for this purpose.

116.13 (b) Persons with dependent children who are determined to be in need of substance use
116.14 disorder treatment pursuant to an assessment under section 260E.20, subdivision 1, or in
116.15 need of chemical dependency treatment pursuant to a case plan under section 260C.201,
116.16 subdivision 6, or 260C.212, shall be assisted by the ~~local agency commissioner~~ to access
116.17 needed treatment services. Treatment services must be appropriate for the individual or
116.18 family, which may include long-term care treatment or treatment in a facility that allows
116.19 the dependent children to stay in the treatment facility. The county shall pay for out-of-home
116.20 placement costs, if applicable.

116.21 (c) Notwithstanding paragraph (a), any person enrolled in medical assistance or
116.22 MinnesotaCare is eligible for room and board services under section 254B.05, subdivision
116.23 5, paragraph (b), clause (9).

116.24 (d) A client is eligible to have substance use disorder treatment paid for with funds from
116.25 the behavioral health fund when the client:

116.26 (1) is eligible for MFIP as determined under chapter 142G;

116.27 (2) is eligible for medical assistance as determined under Minnesota Rules, parts
116.28 9505.0010 to ~~9505.0150~~ 9505.140;

161.25 Sec. 20. Minnesota Statutes 2024, section 254B.04, subdivision 1a, is amended to read:

161.26 Subd. 1a. **Client eligibility.** (a) Persons eligible for benefits under Code of Federal
161.27 Regulations, title 25, part 20, who meet the income standards of section 256B.056,
161.28 subdivision 4, and are not enrolled in medical assistance, are entitled to behavioral health
161.29 fund services. State money appropriated for this paragraph must be placed in a separate
161.30 account established for this purpose.

161.31 (b) Persons with dependent children who are determined to be in need of substance use
161.32 disorder treatment pursuant to an assessment under section 260E.20, subdivision 1, or in
162.1 need of chemical dependency treatment pursuant to a case plan under section 260C.201,
162.2 subdivision 6, or 260C.212, shall be assisted by the ~~local agency~~ to access needed treatment
162.3 services. Treatment services must be appropriate for the individual or family, which may
162.4 include long-term care treatment or treatment in a facility that allows the dependent children
162.5 to stay in the treatment facility. The county shall pay for out-of-home placement costs, if
162.6 applicable.

162.7 (c) Notwithstanding paragraph (a), any person enrolled in medical assistance or
162.8 MinnesotaCare is eligible for room and board services under section 254B.05, subdivision
162.9 5, paragraph (b), clause (9).

162.10 (d) A client is eligible to have substance use disorder treatment paid for with funds from
162.11 the behavioral health fund when the client:

162.12 (1) is eligible for MFIP as determined under chapter 142G;

162.13 (2) is eligible for medical assistance as determined under Minnesota Rules, parts
162.14 9505.0010 to ~~9505.0150~~ 9505.140;

116.29 (3) is eligible for general assistance, general assistance medical care, or work readiness
116.30 as determined under Minnesota Rules, parts 9500.1200 to ~~9500.1318~~ 9500.1272; or

116.31 (4) has income that is within current household size and income guidelines for entitled
116.32 persons, as defined in this subdivision and subdivision 7.

117.1 (e) Clients who meet the financial eligibility requirement in paragraph (a) and who have
117.2 a third-party payment source are eligible for the behavioral health fund if the third-party
117.3 payment source pays less than 100 percent of the cost of treatment services for eligible
117.4 clients.

117.5 (f) A client is ineligible to have substance use disorder treatment services paid for with
117.6 behavioral health fund money if the client:

117.7 (1) has an income that exceeds current household size and income guidelines for entitled
117.8 persons as defined in this subdivision and subdivision 7; or

117.9 (2) has an available third-party payment source that will pay the total cost of the client's
117.10 treatment.

117.11 (g) A client who is disenrolled from a state prepaid health plan during a treatment episode
117.12 is eligible for continued treatment service that is paid for by the behavioral health fund until
117.13 the treatment episode is completed or the client is re-enrolled in a state prepaid health plan
117.14 if the client:

117.15 (1) continues to be enrolled in MinnesotaCare, medical assistance, or general assistance
117.16 medical care; or

117.17 (2) is eligible according to paragraphs (a) and (b) and is determined eligible by ~~a local~~
117.18 ~~agency~~ the commissioner under section 254B.04.

117.19 (h) When a county commits a client under chapter 253B to a regional treatment center
117.20 for substance use disorder services and the client is ineligible for the behavioral health fund,
117.21 the county is responsible for the payment to the regional treatment center according to
117.22 section 254B.05, subdivision 4.

117.23 (i) Persons enrolled in MinnesotaCare are eligible for room and board services when
117.24 provided through intensive residential treatment services and residential crisis services under
117.25 section 256B.0622.

117.26 (j) A person is eligible for one 60-consecutive-calendar-day period per year. A person
117.27 may submit a request for additional eligibility to the commissioner. A person denied
117.28 additional eligibility under this paragraph may request a state agency hearing under section
117.29 256.045.

117.30 EFFECTIVE DATE. Paragraph (d) is effective July 1, 2025. Paragraphs (b), (g), and
117.31 (j) are effective July 1, 2026.

162.15 (3) is eligible for general assistance, general assistance medical care, or work readiness
162.16 as determined under Minnesota Rules, parts 9500.1200 to ~~9500.1318~~ 9500.1272; or

162.17 (4) has income that is within current household size and income guidelines for entitled
162.18 persons, as defined in this subdivision and subdivision 7.

162.19 (e) Clients who meet the financial eligibility requirement in paragraph (a) and who have
162.20 a third-party payment source are eligible for the behavioral health fund if the third-party
162.21 payment source pays less than 100 percent of the cost of treatment services for eligible
162.22 clients.

162.23 (f) A client is ineligible to have substance use disorder treatment services paid for with
162.24 behavioral health fund money if the client:

162.25 (1) has an income that exceeds current household size and income guidelines for entitled
162.26 persons as defined in this subdivision and subdivision 7; or

162.27 (2) has an available third-party payment source that will pay the total cost of the client's
162.28 treatment.

162.29 (g) A client who is disenrolled from a state prepaid health plan during a treatment episode
162.30 is eligible for continued treatment service that is paid for by the behavioral health fund until
162.31 the treatment episode is completed or the client is re-enrolled in a state prepaid health plan
162.32 if the client:

163.1 (1) continues to be enrolled in MinnesotaCare, medical assistance, or general assistance
163.2 medical care; or

163.3 (2) is eligible according to paragraphs (a) and (b) and is determined eligible by ~~a local~~
163.4 ~~agency~~ under section 254B.04.

163.5 (h) When a county commits a client under chapter 253B to a regional treatment center
163.6 for substance use disorder services and the client is ineligible for the behavioral health fund,
163.7 the county is responsible for the payment to the regional treatment center according to
163.8 section 254B.05, subdivision 4.

163.9 (i) Persons enrolled in MinnesotaCare are eligible for room and board services when
163.10 provided through intensive residential treatment services and residential crisis services under
163.11 section 256B.0622.

163.12 (j) A person is eligible for one 60-consecutive-calendar-day period per year. A person
163.13 may submit a request for additional eligibility to the commissioner. A person denied
163.14 additional eligibility under this paragraph may request a state agency hearing under section
163.15 256.045.

163.16 EFFECTIVE DATE. This section is effective July 1, 2026, except the amendments to
163.17 paragraph (d) are effective July 1, 2025.

118.1 Sec. 39. Minnesota Statutes 2024, section 254B.04, subdivision 5, is amended to read:

118.2 Subd. 5. ~~Local agency~~ **Commissioner responsibility to provide administrative**
118.3 **services.** The ~~local agency~~ commissioner of human services may employ individuals to
118.4 conduct administrative activities and facilitate access to substance use disorder treatment
118.5 services.

118.6 **EFFECTIVE DATE.** This section is effective July 1, 2026.

118.7 Sec. 40. Minnesota Statutes 2024, section 254B.04, subdivision 6, is amended to read:

118.8 Subd. 6. ~~Local agency~~ **Commissioner to determine client financial eligibility.** (a)
118.9 The ~~local agency~~ commissioner shall determine a client's financial eligibility for the
118.10 behavioral health fund according to section 254B.04, subdivision 1a, with the income
118.11 calculated prospectively for one year from the date of request. The ~~local agency~~ commissioner
118.12 shall pay for eligible clients according to chapter 256G. Client eligibility must be determined
118.13 using only forms prescribed by the commissioner ~~unless the local agency has a reasonable~~
118.14 ~~basis for believing that the information submitted on a form is false.~~ To determine a client's
118.15 eligibility, the ~~local agency~~ commissioner must determine the client's income, the size of
118.16 the client's household, the availability of a third-party payment source, and a responsible
118.17 relative's ability to pay for the client's substance use disorder treatment.

118.18 (b) A client who is a minor child must not be deemed to have income available to pay
118.19 for substance use disorder treatment, unless the minor child is responsible for payment under
118.20 section 144.347 for substance use disorder treatment services sought under section 144.343,
118.21 subdivision 1.

118.22 (c) The ~~local agency~~ commissioner must determine the client's household size as follows:

118.23 (1) if the client is a minor child, the household size includes the following persons living
118.24 in the same dwelling unit:

118.25 (i) the client;

118.26 (ii) the client's birth or adoptive parents; and

118.27 (iii) the client's siblings who are minors; and

118.28 (2) if the client is an adult, the household size includes the following persons living in
118.29 the same dwelling unit:

118.30 (i) the client;

118.31 (ii) the client's spouse;

119.1 (iii) the client's minor children; and

119.2 (iv) the client's spouse's minor children.

119.3 For purposes of this paragraph, household size includes a person listed in clauses (1) and
119.4 (2) who is in an out-of-home placement if a person listed in clause (1) or (2) is contributing
119.5 to the cost of care of the person in out-of-home placement.

119.6 (d) The ~~local agency~~ commissioner must determine the client's current prepaid health
119.7 plan enrollment, the availability of a third-party payment source, including the availability
119.8 of total payment, partial payment, and amount of co-payment.

119.9 (e) The local agency must provide the required eligibility information to the department
119.10 in the manner specified by the department.

119.11 ~~(f)~~ (e) The ~~local agency~~ commissioner shall require the client and policyholder to
119.12 conditionally assign to the department the client and policyholder's rights and the rights of
119.13 minor children to benefits or services provided to the client if the department is required to
119.14 collect from a third-party pay source.

119.15 ~~(g)~~ (f) The ~~local agency~~ commissioner must ~~redetermine~~ determine a client's eligibility
119.16 for the behavioral health fund ~~every 12 months~~ for a 60-consecutive-calendar-day period
119.17 per calendar year.

119.18 ~~(h)~~ (g) A client, responsible relative, and policyholder must provide income or wage
119.19 verification, household size verification, and must make an assignment of third-party payment
119.20 rights under paragraph ~~(f)~~ (e). If a client, responsible relative, or policyholder does not
119.21 comply with the provisions of this subdivision, the client is ineligible for behavioral health
119.22 fund payment for substance use disorder treatment, and the client and responsible relative
119.23 must be obligated to pay for the full cost of substance use disorder treatment services
119.24 provided to the client.

119.25 **EFFECTIVE DATE.** This section is effective July 1, 2026.

119.26 Sec. 41. Minnesota Statutes 2024, section 254B.04, subdivision 6a, is amended to read:

119.27 Subd. 6a. **Span of eligibility.** The ~~local agency~~ commissioner must enter the financial
119.28 eligibility span within five business days of a request. If the comprehensive assessment is
119.29 completed within the timelines required under chapter 245G, then the span of eligibility
119.30 must begin on the date services were initiated. If the comprehensive assessment is not
119.31 completed within the timelines required under chapter 245G, then the span of eligibility
119.32 must begin on the date the comprehensive assessment was completed.

120.1 **EFFECTIVE DATE.** This section is effective July 1, 2026.

120.2 Sec. 42. Minnesota Statutes 2024, section 254B.05, subdivision 1, is amended to read:

120.3 Subdivision 1. **Licensure or certification required.** (a) Programs licensed by the
120.4 commissioner are eligible vendors. Hospitals may apply for and receive licenses to be
120.5 eligible vendors, notwithstanding the provisions of section 245A.03. American Indian
120.6 programs that provide substance use disorder treatment, extended care, transitional residence,
120.7 or outpatient treatment services, and are licensed by tribal government are eligible vendors.

163.18 Sec. 21. Minnesota Statutes 2024, section 254B.05, subdivision 1, is amended to read:

163.19 Subdivision 1. **Licensure or certification required.** (a) Programs licensed by the
163.20 commissioner are eligible vendors. Hospitals may apply for and receive licenses to be
163.21 eligible vendors, notwithstanding the provisions of section 245A.03. American Indian
163.22 programs that provide substance use disorder treatment, extended care, transitional residence,
163.23 or outpatient treatment services, and are licensed by tribal government are eligible vendors.

120.8 (b) A licensed professional in private practice as defined in section 245G.01, subdivision
120.9 17, who meets the requirements of section 245G.11, subdivisions 1 and 4, is an eligible
120.10 vendor of a comprehensive assessment provided according to section 254A.19, subdivision
120.11 3, and treatment services provided according to sections 245G.06 and 245G.07, ~~subdivision~~
120.12 ~~1, paragraphs (a), clauses (1) to (5), and (b); and subdivision 2, clauses (1) to (6); subdivisions~~
120.13 ~~1, 1a, and 1b.~~

120.14 (c) A county is an eligible vendor for a comprehensive assessment when provided by
120.15 an individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 5,
120.16 and completed according to the requirements of section 254A.19, subdivision 3. A county
120.17 is an eligible vendor of ~~care treatment~~ coordination services when provided by an individual
120.18 who meets the staffing credentials of section 245G.11, subdivisions 1 and 7, and provided
120.19 according to the requirements of section 245G.07, subdivision ~~1, paragraph (a), clause (5)~~
120.20 ~~1b.~~ A county is an eligible vendor of peer recovery services when the services are provided
120.21 by an individual who meets the requirements of section 245G.11, subdivision 8, and
120.22 according to section 254B.052.

120.23 (d) A recovery community organization that meets the requirements of clauses (1) to
120.24 (14), complies with the training requirements in section 254B.052, subdivision 4, and meets
120.25 certification or accreditation requirements of the Alliance for Recovery Centered
120.26 Organizations, the Council on Accreditation of Peer Recovery Support Services, or a
120.27 Minnesota statewide recovery organization identified by the commissioner is an eligible
120.28 vendor of peer recovery support services. A Minnesota statewide recovery organization
120.29 identified by the commissioner must update recovery community organization applicants
120.30 for certification or accreditation on the status of the application within 45 days of receipt.
120.31 If the approved statewide recovery organization denies an application, it must provide a
120.32 written explanation for the denial to the recovery community organization. Eligible vendors
120.33 under this paragraph must:

121.1 (1) be nonprofit organizations under section 501(c)(3) of the Internal Revenue Code, be
121.2 free from conflicting self-interests, and be autonomous in decision-making, program
121.3 development, peer recovery support services provided, and advocacy efforts for the purpose
121.4 of supporting the recovery community organization's mission;

121.5 (2) be led and governed by individuals in the recovery community, with more than 50
121.6 percent of the board of directors or advisory board members self-identifying as people in
121.7 personal recovery from substance use disorders;

121.8 (3) have a mission statement and conduct corresponding activities indicating that the
121.9 organization's primary purpose is to support recovery from substance use disorder;

121.10 (4) demonstrate ongoing community engagement with the identified primary region and
121.11 population served by the organization, including individuals in recovery and their families,
121.12 friends, and recovery allies;

163.24 (b) A licensed professional in private practice as defined in section 245G.01, subdivision
163.25 17, who meets the requirements of section 245G.11, subdivisions 1 and 4, is an eligible
163.26 vendor of a comprehensive assessment provided according to section 254A.19, subdivision
163.27 3, and treatment services provided according to sections 245G.06 and 245G.07, ~~subdivision~~
163.28 ~~1, paragraphs (a), clauses (1) to (5), and (b); and subdivision 2, clauses (1) to (6); subdivisions~~
163.29 ~~1, 1a, and 1b.~~

163.30 (c) A county is an eligible vendor for a comprehensive assessment when provided by
163.31 an individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 5,
163.32 and completed according to the requirements of section 254A.19, subdivision 3. A county
163.33 is an eligible vendor of ~~care treatment~~ coordination services when provided by an individual
164.1 who meets the staffing credentials of section 245G.11, subdivisions 1 and 7, and provided
164.2 according to the requirements of section 245G.07, subdivision ~~1, paragraph (a), clause (5)~~
164.3 ~~1b.~~ A county is an eligible vendor of peer recovery services when the services are provided
164.4 by an individual who meets the requirements of section 245G.11, subdivision 8, and
164.5 according to section 254B.052.

164.6 (d) A recovery community organization that meets the requirements of clauses (1) to
164.7 (14) and meets certification or accreditation requirements of the Alliance for Recovery
164.8 Centered Organizations, the Council on Accreditation of Peer Recovery Support Services,
164.9 or a Minnesota statewide recovery organization identified by the commissioner is an eligible
164.10 vendor of peer recovery support services. A Minnesota statewide recovery organization
164.11 identified by the commissioner must update recovery community organization applicants
164.12 for certification or accreditation on the status of the application within 45 days of receipt.
164.13 If the approved statewide recovery organization denies an application, it must provide a
164.14 written explanation for the denial to the recovery community organization. Eligible vendors
164.15 under this paragraph must:

164.16 (1) be nonprofit organizations under section 501(c)(3) of the Internal Revenue Code, be
164.17 free from conflicting self-interests, and be autonomous in decision-making, program
164.18 development, peer recovery support services provided, and advocacy efforts for the purpose
164.19 of supporting the recovery community organization's mission;

164.20 (2) be led and governed by individuals in the recovery community, with more than 50
164.21 percent of the board of directors or advisory board members self-identifying as people in
164.22 personal recovery from substance use disorders;

164.23 (3) have a mission statement and conduct corresponding activities indicating that the
164.24 organization's primary purpose is to support recovery from substance use disorder;

164.25 (4) demonstrate ongoing community engagement with the identified primary region and
164.26 population served by the organization, including individuals in recovery and their families,
164.27 friends, and recovery allies;

121.13 (5) be accountable to the recovery community through documented priority-setting and
121.14 participatory decision-making processes that promote the engagement of, and consultation
121.15 with, people in recovery and their families, friends, and recovery allies;

121.16 (6) provide nonclinical peer recovery support services, including but not limited to
121.17 recovery support groups, recovery coaching, telephone recovery support, skill-building,
121.18 and harm-reduction activities, and provide recovery public education and advocacy;

121.19 (7) have written policies that allow for and support opportunities for all paths toward
121.20 recovery and refrain from excluding anyone based on their chosen recovery path, which
121.21 may include but is not limited to harm reduction paths, faith-based paths, and nonfaith-based
121.22 paths;

121.23 (8) maintain organizational practices to meet the needs of Black, Indigenous, and people
121.24 of color communities, LGBTQ+ communities, and other underrepresented or marginalized
121.25 communities. Organizational practices may include board and staff training, service offerings,
121.26 advocacy efforts, and culturally informed outreach and services;

121.27 (9) use recovery-friendly language in all media and written materials that is supportive
121.28 of and promotes recovery across diverse geographical and cultural contexts and reduces
121.29 stigma;

121.30 (10) establish and maintain a publicly available recovery community organization code
121.31 of ethics and grievance policy and procedures;

121.32 (11) not classify or treat any recovery peer hired on or after July 1, 2024, as an
121.33 independent contractor;

122.1 (12) not classify or treat any recovery peer as an independent contractor on or after
122.2 January 1, 2025;

122.3 (13) provide an orientation for recovery peers that includes an overview of the consumer
122.4 advocacy services provided by the Ombudsman for Mental Health and Developmental
122.5 Disabilities and other relevant advocacy services; and

122.6 (14) provide notice to peer recovery support services participants that includes the
122.7 following statement: "If you have a complaint about the provider or the person providing
122.8 your peer recovery support services, you may contact the Minnesota Alliance of Recovery
122.9 Community Organizations. You may also contact the Office of Ombudsman for Mental
122.10 Health and Developmental Disabilities." The statement must also include:

122.11 (i) the telephone number, website address, email address, and mailing address of the
122.12 Minnesota Alliance of Recovery Community Organizations and the Office of Ombudsman
122.13 for Mental Health and Developmental Disabilities;

122.14 (ii) the recovery community organization's name, address, email, telephone number, and
122.15 name or title of the person at the recovery community organization to whom problems or
122.16 complaints may be directed; and

164.28 (5) be accountable to the recovery community through documented priority-setting and
164.29 participatory decision-making processes that promote the engagement of, and consultation
164.30 with, people in recovery and their families, friends, and recovery allies;

164.31 (6) provide nonclinical peer recovery support services, including but not limited to
164.32 recovery support groups, recovery coaching, telephone recovery support, skill-building,
164.33 and harm-reduction activities, and provide recovery public education and advocacy;

165.1 (7) have written policies that allow for and support opportunities for all paths toward
165.2 recovery and refrain from excluding anyone based on their chosen recovery path, which
165.3 may include but is not limited to harm reduction paths, faith-based paths, and nonfaith-based
165.4 paths;

165.5 (8) maintain organizational practices to meet the needs of Black, Indigenous, and people
165.6 of color communities, LGBTQ+ communities, and other underrepresented or marginalized
165.7 communities. Organizational practices may include board and staff training, service offerings,
165.8 advocacy efforts, and culturally informed outreach and services;

165.9 (9) use recovery-friendly language in all media and written materials that is supportive
165.10 of and promotes recovery across diverse geographical and cultural contexts and reduces
165.11 stigma;

165.12 (10) establish and maintain a publicly available recovery community organization code
165.13 of ethics and grievance policy and procedures;

165.14 (11) not classify or treat any recovery peer hired on or after July 1, 2024, as an
165.15 independent contractor;

165.16 (12) not classify or treat any recovery peer as an independent contractor on or after
165.17 January 1, 2025;

165.18 (13) provide an orientation for recovery peers that includes an overview of the consumer
165.19 advocacy services provided by the Ombudsman for Mental Health and Developmental
165.20 Disabilities and other relevant advocacy services; and

165.21 (14) provide notice to peer recovery support services participants that includes the
165.22 following statement: "If you have a complaint about the provider or the person providing
165.23 your peer recovery support services, you may contact the Minnesota Alliance of Recovery
165.24 Community Organizations. You may also contact the Office of Ombudsman for Mental
165.25 Health and Developmental Disabilities." The statement must also include:

165.26 (i) the telephone number, website address, email address, and mailing address of the
165.27 Minnesota Alliance of Recovery Community Organizations and the Office of Ombudsman
165.28 for Mental Health and Developmental Disabilities;

165.29 (ii) the recovery community organization's name, address, email, telephone number, and
165.30 name or title of the person at the recovery community organization to whom problems or
165.31 complaints may be directed; and

122.17 (iii) a statement that the recovery community organization will not retaliate against a
122.18 peer recovery support services participant because of a complaint.

122.19 (e) A recovery community organization approved by the commissioner before June 30,
122.20 2023, must have begun the application process as required by an approved certifying or
122.21 accrediting entity and have begun the process to meet the requirements under paragraph (d)
122.22 by September 1, 2024, in order to be considered as an eligible vendor of peer recovery
122.23 support services.

122.24 (f) A recovery community organization that is aggrieved by an accreditation, certification,
122.25 or membership determination and believes it meets the requirements under paragraph (d)
122.26 may appeal the determination under section 256.045, subdivision 3, paragraph (a), clause
122.27 (14), for reconsideration as an eligible vendor. If the human services judge determines that
122.28 the recovery community organization meets the requirements under paragraph (d), the
122.29 recovery community organization is an eligible vendor of peer recovery support services.

122.30 (g) All recovery community organizations must be certified or accredited by an entity
122.31 listed in paragraph (d) by June 30, 2025.

122.32 (h) Detoxification programs licensed under Minnesota Rules, parts 9530.6510 to
122.33 9530.6590, are not eligible vendors. Programs that are not licensed as a residential or
123.1 nonresidential substance use disorder treatment or withdrawal management program by the
123.2 commissioner or by tribal government or do not meet the requirements of subdivisions 1a
123.3 and 1b are not eligible vendors.

123.4 (i) Hospitals, federally qualified health centers, and rural health clinics are eligible
123.5 vendors of a comprehensive assessment when the comprehensive assessment is completed
123.6 according to section 254A.19, subdivision 3, and by an individual who meets the criteria
123.7 of an alcohol and drug counselor according to section 245G.11, subdivision 5. The alcohol
123.8 and drug counselor must be individually enrolled with the commissioner and reported on
123.9 the claim as the individual who provided the service.

123.10 (j) Any complaints about a recovery community organization or peer recovery support
123.11 services may be made to and reviewed or investigated by the ombudsperson for behavioral
123.12 health and developmental disabilities under sections 245.91 and 245.94.

123.13 EFFECTIVE DATE. This section is effective July 1, 2026, or upon federal approval,
123.14 whichever is later. The commissioner of human services shall notify the revisor of statutes
123.15 when federal approval is obtained.

123.16 Sec. 43. Minnesota Statutes 2024, section 254B.05, subdivision 1a, is amended to read:

123.17 Subd. 1a. Room and board provider requirements. (a) Vendors of room and board
123.18 are eligible for behavioral health fund payment if the vendor:

123.19 (1) has rules prohibiting residents bringing chemicals into the facility or using chemicals
123.20 while residing in the facility and provide consequences for infractions of those rules;

165.32 (iii) a statement that the recovery community organization will not retaliate against a
165.33 peer recovery support services participant because of a complaint.

166.1 (e) A recovery community organization approved by the commissioner before June 30,
166.2 2023, must have begun the application process as required by an approved certifying or
166.3 accrediting entity and have begun the process to meet the requirements under paragraph (d)
166.4 by September 1, 2024, in order to be considered as an eligible vendor of peer recovery
166.5 support services.

166.6 (f) A recovery community organization that is aggrieved by an accreditation, certification,
166.7 or membership determination and believes it meets the requirements under paragraph (d)
166.8 may appeal the determination under section 256.045, subdivision 3, paragraph (a), clause
166.9 (14), for reconsideration as an eligible vendor. If the human services judge determines that
166.10 the recovery community organization meets the requirements under paragraph (d), the
166.11 recovery community organization is an eligible vendor of peer recovery support services.

166.12 (g) All recovery community organizations must be certified or accredited by an entity
166.13 listed in paragraph (d) by June 30, 2025.

166.14 (h) Detoxification programs licensed under Minnesota Rules, parts 9530.6510 to
166.15 9530.6590, are not eligible vendors. Programs that are not licensed as a residential or
166.16 nonresidential substance use disorder treatment or withdrawal management program by the
166.17 commissioner or by tribal government or do not meet the requirements of subdivisions 1a
166.18 and 1b are not eligible vendors.

166.19 (i) Hospitals, federally qualified health centers, and rural health clinics are eligible
166.20 vendors of a comprehensive assessment when the comprehensive assessment is completed
166.21 according to section 254A.19, subdivision 3, and by an individual who meets the criteria
166.22 of an alcohol and drug counselor according to section 245G.11, subdivision 5. The alcohol
166.23 and drug counselor must be individually enrolled with the commissioner and reported on
166.24 the claim as the individual who provided the service.

166.25 (j) Any complaints about a recovery community organization or peer recovery support
166.26 services may be made to and reviewed or investigated by the ombudsperson for behavioral
166.27 health and developmental disabilities under sections 245.91 and 245.94.

166.28 EFFECTIVE DATE. This section is effective July 1, 2026, or upon federal approval,
166.29 whichever is later. The commissioner of human services shall notify the revisor of statutes
166.30 when federal approval is obtained.

- 123.21 (2) is determined to meet applicable health and safety requirements;
- 123.22 (3) is not a jail or prison;
- 123.23 (4) is not concurrently receiving funds under chapter 256I for the recipient;
- 123.24 (5) admits individuals who are 18 years of age or older;
- 123.25 (6) is registered as a board and lodging or lodging establishment according to section
- 123.26 157.17;
- 123.27 (7) has awake staff on site whenever a client is present;
- 123.28 (8) has staff who are at least 18 years of age and meet the requirements of section
- 123.29 245G.11, subdivision 1, paragraph (b);
- 123.30 (9) has emergency behavioral procedures that meet the requirements of section 245G.16;
- 124.1 (10) meets the requirements of section 245G.08, subdivision 5, if administering
- 124.2 medications to clients;
- 124.3 (11) meets the abuse prevention requirements of section 245A.65, including a policy on
- 124.4 fraternization and the mandatory reporting requirements of section 626.557;
- 124.5 (12) documents coordination with the treatment provider to ensure compliance with
- 124.6 section 254B.03, subdivision 2;
- 124.7 (13) protects client funds and ensures freedom from exploitation by meeting the
- 124.8 provisions of section 245A.04, subdivision 13;
- 124.9 (14) has a grievance procedure that meets the requirements of section 245G.15,
- 124.10 subdivision 2; and
- 124.11 (15) has sleeping and bathroom facilities for men and women separated by a door that
- 124.12 is locked, has an alarm, or is supervised by awake staff
- 124.13 (b) Programs licensed according to Minnesota Rules, chapter 2960, are exempt from
- 124.14 paragraph (a), clauses (5) to (15).
- 124.15 (c) Programs providing children's mental health crisis admissions and stabilization under
- 124.16 section 245.4882, subdivision 6, are eligible vendors of room and board.
- 124.17 (d) Programs providing children's residential services under section 245.4882, except
- 124.18 services for individuals who have a placement under chapter 260C or 260D, are eligible
- 124.19 vendors of room and board.
- 124.20 (e) Licensed programs providing intensive residential treatment services or residential
- 124.21 crisis stabilization services pursuant to section 256B.0622 or 256B.0624 are eligible vendors
- 124.22 of room and board and are exempt from paragraph (a), clauses (6) to (15).

124.23 (f) A vendor that is not licensed as a residential treatment program must have a policy
124.24 to address staffing coverage when a client may unexpectedly need to be present at the room
124.25 and board site.

124.26 (g) No new vendors for room and board services may be approved after June 30, 2025,
124.27 to receive payments from the behavioral health fund, under the provisions of section 254B.04,
124.28 subdivision 2a. Room and board vendors that were approved and operating prior to July 1,
124.29 2025, may continue to receive payments from the behavioral health fund for services provided
124.30 until June 30, 2027. Room and board vendors providing services in accordance with section
124.31 254B.04, subdivision 2a, will no longer be eligible to claim reimbursement for room and
124.32 board services provided on or after July 1, 2027.

125.1 **EFFECTIVE DATE.** This section is effective the day following final enactment.

125.2 Sec. 44. Minnesota Statutes 2024, section 254B.05, subdivision 5, is amended to read:

125.3 Subd. 5. **Rate requirements.** (a) Subject to the requirements of subdivision 6, the
125.4 commissioner shall establish rates for the following substance use disorder treatment services
125.5 ~~and service enhancements~~ funded under this chapter.:

125.6 (b) ~~Eligible substance use disorder treatment services include:~~

125.7 (1) those licensed, as applicable, according to chapter 245G or applicable Tribal license
125.8 and provided according to the following ASAM levels of care:

125.9 (i) ASAM level 0.5 early intervention services provided according to section 254B.19,
125.10 subdivision 1, clause (1);

125.11 (ii) ASAM level 1.0 outpatient services provided according to section 254B.19,
125.12 subdivision 1, clause (2);

125.13 (iii) ASAM level 2.1 intensive outpatient services provided according to section 254B.19,
125.14 subdivision 1, clause (3);

125.15 (iv) ASAM level 2.5 partial hospitalization services provided according to section
125.16 254B.19, subdivision 1, clause (4);

125.17 (v) ASAM level 3.1 clinically managed low-intensity residential services provided
125.18 according to section 254B.19, subdivision 1, clause (5). ~~The commissioner shall use the~~
125.19 ~~base payment rate of \$79.84 per day for services provided under this item;~~

125.20 (vi) ASAM level 3.1 clinically managed low-intensity residential services provided
125.21 according to section 254B.19, subdivision 1, clause (5), at 15 or more hours of skilled
125.22 treatment services each week. ~~The commissioner shall use the base payment rate of \$166.13~~
125.23 ~~per day for services provided under this item;~~

125.24 (vii) ASAM level 3.3 clinically managed population-specific high-intensity residential
125.25 services provided according to section 254B.19, subdivision 1, clause (6). ~~The commissioner~~

167.1 Sec. 22. Minnesota Statutes 2024, section 254B.05, subdivision 5, is amended to read:

167.2 Subd. 5. **Rate requirements.** (a) Subject to the requirements of subdivision 6, the
167.3 commissioner shall establish rates for the following substance use disorder treatment services
167.4 ~~and service enhancements~~ funded under this chapter.:

167.5 (b) ~~Eligible substance use disorder treatment services include:~~

167.6 (1) those licensed, as applicable, according to chapter 245G or applicable Tribal license
167.7 and provided according to the following ASAM levels of care:

167.8 (i) ASAM level 0.5 early intervention services provided according to section 254B.19,
167.9 subdivision 1, clause (1);

167.10 (ii) ASAM level 1.0 outpatient services provided according to section 254B.19,
167.11 subdivision 1, clause (2);

167.12 (iii) ASAM level 2.1 intensive outpatient services provided according to section 254B.19,
167.13 subdivision 1, clause (3);

167.14 (iv) ASAM level 2.5 partial hospitalization services provided according to section
167.15 254B.19, subdivision 1, clause (4);

167.16 (v) ASAM level 3.1 clinically managed low-intensity residential services provided
167.17 according to section 254B.19, subdivision 1, clause (5). ~~The commissioner shall use the~~
167.18 ~~base payment rate of \$79.84 per day for services provided under this item;~~

167.19 (vi) ASAM level 3.1 clinically managed low-intensity residential services provided
167.20 according to section 254B.19, subdivision 1, clause (5), at 15 or more hours of skilled
167.21 treatment services each week. ~~The commissioner shall use the base payment rate of \$166.13~~
167.22 ~~per day for services provided under this item;~~

167.23 (vii) ASAM level 3.3 clinically managed population-specific high-intensity residential
167.24 services provided according to section 254B.19, subdivision 1, clause (6). ~~The commissioner~~

125.26 ~~shall use the specified base payment rate of \$224.06 per day for services provided under~~
125.27 ~~this item; and~~

125.28 (viii) ASAM level 3.5 clinically managed high-intensity residential services provided
125.29 according to section 254B.19, subdivision 1, clause (7). ~~The commissioner shall use the~~
125.30 ~~specified base payment rate of \$224.06 per day for services provided under this item;~~

125.31 (2) comprehensive assessments provided according to section 254A.19, subdivision 3;

126.1 (3) treatment coordination services provided according to section 245G.07, subdivision
126.2 1, paragraph (a), clause (5);

126.3 (4) peer recovery support services provided according to section 245G.07, subdivision
126.4 ~~2~~ 2a, paragraph (b), clause ~~(8)~~ (2);

126.5 (5) withdrawal management services provided according to chapter 245F;

126.6 (6) hospital-based treatment services that are licensed according to sections 245G.01 to
126.7 245G.17 or applicable Tribal license and licensed as a hospital under sections 144.50 to
126.8 144.56;

126.9 (7) substance use disorder treatment services with medications for opioid use disorder
126.10 provided in an opioid treatment program licensed according to sections 245G.01 to 245G.17
126.11 and 245G.22, or under an applicable Tribal license;

126.12 (8) medium-intensity residential treatment services that provide 15 hours of skilled
126.13 treatment services each week and are licensed according to sections 245G.01 to 245G.17
126.14 and 245G.21 or applicable Tribal license;

126.15 (9) adolescent treatment programs that are licensed as outpatient treatment programs
126.16 according to sections 245G.01 to 245G.18 or as residential treatment programs according
126.17 to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or
126.18 applicable Tribal license;

126.19 (10) ASAM 3.5 clinically managed high-intensity residential services that are licensed
126.20 according to sections 245G.01 to 245G.17 and 245G.21 or applicable Tribal license, which
126.21 provide ASAM level of care 3.5 according to section 254B.19, subdivision 1, clause (7),
126.22 and are provided by a state-operated vendor or to clients who have been civilly committed
126.23 to the commissioner, present the most complex and difficult care needs, and are a potential
126.24 threat to the community; and

126.25 (11) room and board facilities that meet the requirements of subdivision 1a.

126.26 ~~(e)~~ (b) The commissioner shall establish higher rates for programs that meet the
126.27 requirements of paragraph ~~(b)~~ (a) and ~~one of the following additional requirements: the~~
126.28 ~~requirements of one clause in this paragraph.~~

126.29 (1) Programs that serve parents with their children are eligible for an enhanced payment
126.30 rate if the program:

167.25 ~~shall use the specified base payment rate of \$224.06 per day for services provided under~~
167.26 ~~this item; and~~

167.27 (viii) ASAM level 3.5 clinically managed high-intensity residential services provided
167.28 according to section 254B.19, subdivision 1, clause (7). ~~The commissioner shall use the~~
167.29 ~~specified base payment rate of \$224.06 per day for services provided under this item;~~

167.30 (2) comprehensive assessments provided according to section 254A.19, subdivision 3;

167.31 (3) treatment coordination services provided according to section 245G.07, subdivision
167.32 1, paragraph (a), clause (5);

168.1 (4) peer recovery support services provided according to section 245G.07, subdivision
168.2 2, clause (8);

168.3 (5) withdrawal management services provided according to chapter 245F;

168.4 (6) hospital-based treatment services that are licensed according to sections 245G.01 to
168.5 245G.17 or applicable Tribal license and licensed as a hospital under sections 144.50 to
168.6 144.56;

168.7 (7) substance use disorder treatment services with medications for opioid use disorder
168.8 provided in an opioid treatment program licensed according to sections 245G.01 to 245G.17
168.9 and 245G.22, or under an applicable Tribal license;

168.10 (8) medium-intensity residential treatment services that provide 15 hours of skilled
168.11 treatment services each week and are licensed according to sections 245G.01 to 245G.17
168.12 and 245G.21 or applicable Tribal license;

168.13 (9) adolescent treatment programs that are licensed as outpatient treatment programs
168.14 according to sections 245G.01 to 245G.18 or as residential treatment programs according
168.15 to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or
168.16 applicable Tribal license;

168.17 (10) ASAM 3.5 clinically managed high-intensity residential services that are licensed
168.18 according to sections 245G.01 to 245G.17 and 245G.21 or applicable Tribal license, which
168.19 provide ASAM level of care 3.5 according to section 254B.19, subdivision 1, clause (7),
168.20 and are provided by a state-operated vendor or to clients who have been civilly committed
168.21 to the commissioner, present the most complex and difficult care needs, and are a potential
168.22 threat to the community; and

168.23 (11) room and board facilities that meet the requirements of subdivision 1a.

168.24 ~~(e)~~ (b) The commissioner shall establish higher rates for programs that meet the
168.25 requirements of paragraph ~~(b)~~ (a) and ~~one of the following additional requirements: the~~
168.26 ~~requirements of one clause in this paragraph.~~

168.27 (1) Programs that serve parents with their children are eligible for an enhanced payment
168.28 rate if the program:

126.31 (i) provides on-site child care during the hours of treatment activity that:

127.1 (A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter

127.2 9503; or

127.3 (B) is licensed under chapter 245A and sections 245G.01 to 245G.19; or

127.4 (ii) arranges for off-site child care during hours of treatment activity at a facility that is

127.5 licensed under chapter 245A as:

127.6 (A) a child care center under Minnesota Rules, chapter 9503; or

127.7 (B) a family child care home under Minnesota Rules, chapter 9502;

127.8 In order to be eligible for a higher rate under this clause, a program that provides

127.9 arrangements for off-site child care must maintain current documentation at the substance

127.10 use disorder facility of the child care provider's current licensure to provide child care

127.11 services.

127.12 (2) Culturally specific or culturally responsive programs as defined in section 254B.01,

127.13 subdivision 4a; are eligible for an enhanced payment rate.

127.14 (3) Disability responsive programs as defined in section 254B.01, subdivision 4b; are

127.15 eligible for an enhanced payment rate.

127.16 (4) Programs that offer medical services delivered by appropriately credentialed health

127.17 care staff in an amount equal to one hour per client per week are eligible for an enhanced

127.18 payment rate if the medical needs of the client and the nature and provision of any medical

127.19 services provided are documented in the client file; ~~or.~~

127.20 (5) Programs that offer services to individuals with co-occurring mental health and

127.21 substance use disorder problems are eligible for an enhanced payment rate if:

127.22 (i) the program meets the co-occurring requirements in section 245G.20;

127.23 (ii) the program employs a mental health professional as defined in section 245I.04,

127.24 subdivision 2;

127.25 (iii) clients scoring positive on a standardized mental health screen receive a mental

127.26 health diagnostic assessment within ten days of admission;

127.27 (iv) the program has standards for multidisciplinary case review that include a monthly

127.28 review for each client that, at a minimum, includes a licensed mental health professional

127.29 and licensed alcohol and drug counselor, and their involvement in the review is documented;

127.30 (v) family education is offered that addresses mental health and substance use disorder

127.31 and the interaction between the two; and

128.1 (vi) co-occurring counseling staff shall receive eight hours of co-occurring disorder

128.2 training annually.

168.29 (i) provides on-site child care during the hours of treatment activity that:

168.30 (A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter

168.31 9503; or

168.32 (B) is licensed under chapter 245A and sections 245G.01 to 245G.19; or

169.1 (ii) arranges for off-site child care during hours of treatment activity at a facility that is

169.2 licensed under chapter 245A as:

169.3 (A) a child care center under Minnesota Rules, chapter 9503; or

169.4 (B) a family child care home under Minnesota Rules, chapter 9502;

169.5 In order to be eligible for a higher rate under this clause, a program that provides

169.6 arrangements for off-site child care must maintain current documentation at the substance

169.7 use disorder facility of the child care provider's current licensure to provide child care

169.8 services.

169.9 (2) Culturally specific or culturally responsive programs as defined in section 254B.01,

169.10 subdivision 4a; are eligible for an enhanced payment rate.

169.11 (3) Disability responsive programs as defined in section 254B.01, subdivision 4b; are

169.12 eligible for an enhanced payment rate.

169.13 (4) Programs that offer medical services delivered by appropriately credentialed health

169.14 care staff in an amount equal to one hour per client per week are eligible for an enhanced

169.15 payment rate if the medical needs of the client and the nature and provision of any medical

169.16 services provided are documented in the client file; ~~or.~~

169.17 (5) Programs that offer services to individuals with co-occurring mental health and

169.18 substance use disorder problems are eligible for an enhanced payment rate if:

169.19 (i) the program meets the co-occurring requirements in section 245G.20;

169.20 (ii) the program employs a mental health professional as defined in section 245I.04,

169.21 subdivision 2;

169.22 (iii) clients scoring positive on a standardized mental health screen receive a mental

169.23 health diagnostic assessment within ten days of admission;

169.24 (iv) the program has standards for multidisciplinary case review that include a monthly

169.25 review for each client that, at a minimum, includes a licensed mental health professional

169.26 and licensed alcohol and drug counselor, and their involvement in the review is documented;

169.27 (v) family education is offered that addresses mental health and substance use disorder

169.28 and the interaction between the two; and

169.29 (vi) co-occurring counseling staff shall receive eight hours of co-occurring disorder

169.30 training annually.

128.3 ~~(d)~~ In order to be eligible for a higher rate under paragraph (c), clause (1), a program
128.4 that provides arrangements for off-site child care must maintain current documentation at
128.5 the substance use disorder facility of the child care provider's current licensure to provide
128.6 child care services.

128.7 ~~(e)~~ Adolescent residential programs that meet the requirements of Minnesota Rules, parts
128.8 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements
128.9 in ~~paragraph (e), clause (5)~~; items (i) to (iv).

128.10 ~~(f)~~ (c) Substance use disorder services that are otherwise covered as direct face-to-face
128.11 services may be provided via telehealth as defined in section 256B.0625, subdivision 3b.
128.12 The use of telehealth to deliver services must be medically appropriate to the condition and
128.13 needs of the person being served. Reimbursement shall be at the same rates and under the
128.14 same conditions that would otherwise apply to direct face-to-face services.

128.15 ~~(g)~~ (d) For the purpose of reimbursement under this section, substance use disorder
128.16 treatment services provided in a group setting without a group participant maximum or
128.17 maximum client to staff ratio under chapter 245G shall not exceed a client to staff ratio of
128.18 48 to one. At least one of the attending staff must meet the qualifications as established
128.19 under this chapter for the type of treatment service provided. A recovery peer may not be
128.20 included as part of the staff ratio.

128.21 ~~(h)~~ (e) Payment for outpatient substance use disorder services that are licensed according
128.22 to sections 245G.01 to 245G.17 is limited to six hours per day or 30 hours per week unless
128.23 prior authorization of a greater number of hours is obtained from the commissioner.

128.24 ~~(i)~~ (f) Payment for substance use disorder services under this section must start from the
128.25 day of service initiation, when the comprehensive assessment is completed within the
128.26 required timelines.

128.27 ~~(j)~~ (g) A license holder that is unable to provide all residential treatment services because
128.28 a client missed services remains eligible to bill for the client's intensity level of services
128.29 under this paragraph if the license holder can document the reason the client missed services
128.30 and the interventions done to address the client's absence.

128.31 ~~(k)~~ (h) Hours in a treatment week may be reduced in observance of federally recognized
128.32 holidays.

128.33 ~~(l)~~ (i) Eligible vendors of peer recovery support services must:

129.1 (1) submit to a review by the commissioner of up to ten percent of all medical assistance
129.2 and behavioral health fund claims to determine the medical necessity of peer recovery
129.3 support services for entities billing for peer recovery support services individually and not
129.4 receiving a daily rate; and

129.5 (2) limit an individual client to 14 hours per week for peer recovery support services
129.6 from an individual provider of peer recovery support services.

170.1 ~~(d)~~ In order to be eligible for a higher rate under paragraph (c), clause (1), a program
170.2 that provides arrangements for off-site child care must maintain current documentation at
170.3 the substance use disorder facility of the child care provider's current licensure to provide
170.4 child care services.

170.5 ~~(e)~~ Adolescent residential programs that meet the requirements of Minnesota Rules, parts
170.6 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements
170.7 in ~~paragraph (e), clause (5)~~; items (i) to (iv).

170.8 ~~(f)~~ (c) Substance use disorder services that are otherwise covered as direct face-to-face
170.9 services may be provided via telehealth as defined in section 256B.0625, subdivision 3b.
170.10 The use of telehealth to deliver services must be medically appropriate to the condition and
170.11 needs of the person being served. Reimbursement shall be at the same rates and under the
170.12 same conditions that would otherwise apply to direct face-to-face services.

170.13 ~~(g)~~ (d) For the purpose of reimbursement under this section, substance use disorder
170.14 treatment services provided in a group setting without a group participant maximum or
170.15 maximum client to staff ratio under chapter 245G shall not exceed a client to staff ratio of
170.16 48 to one. At least one of the attending staff must meet the qualifications as established
170.17 under this chapter for the type of treatment service provided. A recovery peer may not be
170.18 included as part of the staff ratio.

170.19 ~~(h)~~ (e) Payment for outpatient substance use disorder services that are licensed according
170.20 to sections 245G.01 to 245G.17 is limited to six hours per day or 30 hours per week unless
170.21 prior authorization of a greater number of hours is obtained from the commissioner.

170.22 ~~(i)~~ (f) Payment for substance use disorder services under this section must start from the
170.23 day of service initiation, when the comprehensive assessment is completed within the
170.24 required timelines.

170.25 ~~(j)~~ (g) A license holder that is unable to provide all residential treatment services because
170.26 a client missed services remains eligible to bill for the client's intensity level of services
170.27 under this paragraph if the license holder can document the reason the client missed services
170.28 and the interventions done to address the client's absence.

170.29 ~~(k)~~ (h) Hours in a treatment week may be reduced in observance of federally recognized
170.30 holidays.

170.31 ~~(l)~~ (i) Eligible vendors of peer recovery support services must:

170.32 (1) submit to a review by the commissioner of up to ten percent of all medical assistance
170.33 and behavioral health fund claims to determine the medical necessity of peer recovery
171.1 support services for entities billing for peer recovery support services individually and not
171.2 receiving a daily rate; and

171.3 (2) limit an individual client to 14 hours per week for peer recovery support services
171.4 from an individual provider of peer recovery support services.

129.7 ~~(m)~~ (j) Peer recovery support services not provided in accordance with section 254B.052
129.8 are subject to monetary recovery under section 256B.064 as money improperly paid.

129.9 Sec. 45. Minnesota Statutes 2024, section 254B.05, is amended by adding a subdivision
129.10 to read:

129.11 Subd. 6. **Rate adjustments.** (a) Effective for services provided on or after January 1,
129.12 2026, the commissioner must implement the following base payment rates for substance
129.13 use disorder treatment services under subdivision 5, paragraph (a):

129.14 (1) for low-intensity residential services, 100 percent of the modeled rate included in
129.15 the final report required by Laws 2021, First Special Session chapter 7, article 17, section
129.16 18;

129.17 (2) for high-intensity residential services, the rates in effect on December 31, 2025; and

129.18 (3) for all other services not included in clause (1) or (2), 72 percent of the modeled rate
129.19 included in the final report required by Laws 2021, First Special Session chapter 7, article
129.20 17, section 18.

129.21 (b) Effective January 1, 2027, and annually thereafter, the commissioner of human
129.22 services must adjust the payment rates under paragraph (a) according to the change from
129.23 the midpoint of the previous rate year to the midpoint of the rate year for which the rate is
129.24 being determined using the Centers for Medicare and Medicaid Services Medicare Economic
129.25 Index as forecasted in the fourth quarter of the calendar year before the rate year.

129.26 (c) Notwithstanding paragraph (a), the commissioner must not implement a base payment
129.27 rate for a substance use disorder treatment service that is lower than the rate in effect for
129.28 the service on December 31, 2025.

130.1 Sec. 46. Minnesota Statutes 2024, section 254B.052, is amended by adding a subdivision
130.2 to read:

130.3 Subd. 4. **Recovery community organization vendor compliance training.** (a) Effective
130.4 January 1, 2027, in order to enroll as an eligible vendor of peer recovery support services,
130.5 a recovery community organization must require all owners active in day-to-day management
130.6 and operations of the organization and managerial and supervisory employees to complete
130.7 compliance training before applying for enrollment and every three years thereafter.
130.8 Mandatory compliance training format and content must be determined by the commissioner,
130.9 and must include the following topics:

130.10 (1) state and federal program billing, documentation, and service delivery requirements;

130.11 (2) eligible vendor enrollment requirements;

130.12 (3) provider program integrity, including fraud prevention, fraud detection, and penalties;

171.5 ~~(m)~~ (j) Peer recovery support services not provided in accordance with section 254B.052
171.6 are subject to monetary recovery under section 256B.064 as money improperly paid.

171.7 **EFFECTIVE DATE.** This section is effective January 1, 2026.

171.8 Sec. 23. Minnesota Statutes 2024, section 254B.05, is amended by adding a subdivision
171.9 to read:

171.10 Subd. 6. **Rate adjustments.** (a) Effective for services rendered on or after January 1,
171.11 2026, the commissioner must implement the following base payment rates for substance
171.12 use disorder treatment services under subdivision 5, paragraph (a):

171.13 (1) for low-intensity residential, 100 percent of the modeled rate included in the final
171.14 report required by Laws 2021, First Special Session chapter 7, article 17, section 18;

171.15 (2) for high-intensity residential services, the rates in effect on December 31, 2025; and

171.16 (3) for all other services not included in clause (1) or (2), 55 percent of the modeled rate
171.17 included in the final report required by Laws 2021, First Special Session chapter 7, article
171.18 17, section 18.

171.19 (b) Effective January 1, 2028, and annually thereafter, the commissioner of human
171.20 services must adjust the payment rates under paragraph (a) according to the change from
171.21 the midpoint of the previous rate year to the midpoint of the rate year for which the rate is
171.22 being determined using the Centers for Medicare and Medicaid Services Medicare Economic
171.23 Index as forecasted in the fourth quarter of the calendar year before the rate year.

- 130.13 (4) fair labor standards;
- 130.14 (5) workplace safety requirements; and
- 130.15 (6) recent changes in service requirements.
- 130.16 (b) Any new owners active in day-to-day management and operations of the organization
- 130.17 and managerial and supervisory employees must complete the training under this subdivision
- 130.18 in order to be employed by or conduct management and operations activities for the
- 130.19 organization. If the individual moves to another recovery community organization and
- 130.20 serves in a similar ownership or employment capacity, the individual is not required to
- 130.21 repeat the training required under this subdivision if the individual documents completion
- 130.22 of the training within the past three years.
- 130.23 (c) By July 1, 2026, the commissioner must make the training required under this
- 130.24 subdivision available in person, online, or by electronic remote connection.
- 130.25 (d) A recovery community organization enrolled as an eligible vendor before January
- 130.26 1, 2027, must document completion of the compliance training as required under this
- 130.27 subdivision by January 1, 2028, and every three years thereafter.
- 130.28 Sec. 47. Minnesota Statutes 2024, section 254B.06, subdivision 2, is amended to read:
- 130.29 Subd. 2. **Allocation of collections.** The commissioner shall allocate ~~77.05~~ 50 percent
- 130.30 of patient payments and third-party payments to the special revenue account and ~~22.95~~ 50
- 130.31 percent to the county financially responsible for the patient.
- 131.1 **EFFECTIVE DATE.** This section is effective January 1, 2026.

UEH2434-1 ART 4, SEC 24, BELOW, IS ALSO IN THE ARTICLE 6 (PROGRAM INTEGRITY) SIDE BY SIDE, MATCHING WITH H2434-3, ART 6, SEC 15.

- 171.24 Sec. 24. Minnesota Statutes 2024, section 254B.06, is amended by adding a subdivision
- 171.25 to read:
- 171.26 Subd. 5. **Prohibition of duplicative claim submission.** (a) For time-based claims,
- 171.27 submissions must follow the guidelines in the Centers for Medicare and Medicaid Services'
- 171.28 Healthcare Common Procedure Coding System and the American Medical Association's
- 171.29 Current Procedural Terminology to determine the appropriate units of time to report.
- 171.30 (b) More than half the duration of a time-based code must be spent performing the service
- 171.31 to be eligible under this section. Any provision of service during the remaining balance of
- 172.1 the unit of time is not eligible for any other claims submission and would be considered a
- 172.2 duplicative claim submission.

131.2 Sec. 48. Minnesota Statutes 2024, section 254B.09, subdivision 2, is amended to read:

131.3 Subd. 2. **American Indian agreements.** The commissioner may enter into agreements
131.4 with federally recognized Tribal units to pay for substance use disorder treatment services
131.5 provided under Laws 1986, chapter 394, sections 8 to 20. The agreements must clarify how
131.6 the governing body of the Tribal unit fulfills ~~local agency~~ the Tribal unit's responsibilities
131.7 regarding the form and manner of invoicing.

131.8 **EFFECTIVE DATE.** This section is effective July 1, 2026.

131.9 Sec. 49. Minnesota Statutes 2024, section 254B.19, subdivision 1, is amended to read:

131.10 Subdivision 1. **Level of care requirements.** (a) For each client assigned an ASAM level
131.11 of care, eligible vendors must implement the standards set by the ASAM for the respective
131.12 level of care. Additionally, vendors must meet the following requirements:

131.13 (1) For ASAM level 0.5 early intervention targeting individuals who are at risk of
131.14 developing a substance-related problem but may not have a diagnosed substance use disorder,
131.15 early intervention services may include individual or group counseling, treatment
131.16 coordination, peer recovery support, screening brief intervention, and referral to treatment
131.17 provided according to section 254A.03, subdivision 3, paragraph (c).

131.18 (2) For ASAM level 1.0 outpatient clients, adults must receive up to eight hours per
131.19 week of ~~skilled psychosocial~~ treatment services and adolescents must receive up to five
131.20 hours per week. Services must be licensed according to section 245G.20 and meet
131.21 requirements under section 256B.0759. ~~Peer recovery~~ Ancillary services and treatment
131.22 coordination may be provided beyond the hourly ~~skilled psychosocial~~ treatment service
131.23 hours allowable per week.

131.24 (3) For ASAM level 2.1 intensive outpatient clients, adults must receive nine to 19 hours
131.25 per week of ~~skilled psychosocial~~ treatment services and adolescents must receive six or
131.26 more hours per week. Vendors must be licensed according to section 245G.20 and must
131.27 meet requirements under section 256B.0759. ~~Peer recovery~~ Ancillary services and treatment
131.28 coordination may be provided beyond the hourly ~~skilled psychosocial~~ treatment service
131.29 hours allowable per week. If clinically indicated on the client's treatment plan, this service
131.30 may be provided in conjunction with room and board according to section 254B.05,
131.31 subdivision 1a.

132.1 (4) For ASAM level 2.5 partial hospitalization clients, adults must receive 20 hours or
132.2 more of ~~skilled psychosocial~~ treatment services. Services must be licensed according to
132.3 section 245G.20 ~~and must meet requirements under section 256B.0759.~~ Level 2.5 is for
132.4 clients who need daily monitoring in a structured setting, as directed by the individual

172.3 (c) A provider may only round up to the next whole number of service units on a
172.4 submitted claim when more than one and one-half times the defined value of the code has
172.5 occurred and no additional time increment code exists.

172.6 **EFFECTIVE DATE.** This section is effective July 1, 2025.

172.7 Sec. 25. Minnesota Statutes 2024, section 254B.09, subdivision 2, is amended to read:

172.8 Subd. 2. **American Indian agreements.** The commissioner may enter into agreements
172.9 with federally recognized Tribal units to pay for substance use disorder treatment services
172.10 provided under Laws 1986, chapter 394, sections 8 to 20. The agreements must clarify how
172.11 the governing body of the Tribal unit fulfills ~~local agency~~ the Tribal unit's responsibilities
172.12 regarding the form and manner of invoicing.

172.13 **EFFECTIVE DATE.** This section is effective July 1, 2026.

172.14 Sec. 26. Minnesota Statutes 2024, section 254B.19, subdivision 1, is amended to read:

172.15 Subdivision 1. **Level of care requirements.** (a) For each client assigned an ASAM level
172.16 of care, eligible vendors must implement the standards set by the ASAM for the respective
172.17 level of care. Additionally, vendors must meet the following requirements:

172.18 (1) For ASAM level 0.5 early intervention targeting individuals who are at risk of
172.19 developing a substance-related problem but may not have a diagnosed substance use disorder,
172.20 early intervention services may include individual or group counseling, treatment
172.21 coordination, peer recovery support, screening brief intervention, and referral to treatment
172.22 provided according to section 254A.03, subdivision 3, paragraph (c).

172.23 (2) For ASAM level 1.0 outpatient clients, adults must receive up to eight hours per
172.24 week of ~~skilled psychosocial~~ treatment services and adolescents must receive up to five
172.25 hours per week. Services must be licensed according to section 245G.20 and meet
172.26 requirements under section 256B.0759. ~~Peer recovery~~ Ancillary services and treatment
172.27 coordination may be provided beyond the hourly ~~skilled psychosocial~~ treatment service
172.28 hours allowable per week.

172.29 (3) For ASAM level 2.1 intensive outpatient clients, adults must receive nine to 19 hours
172.30 per week of ~~skilled psychosocial~~ treatment services and adolescents must receive six or
172.31 more hours per week. Vendors must be licensed according to section 245G.20 and must
172.32 meet requirements under section 256B.0759. ~~Peer recovery~~ Ancillary services and treatment
173.1 coordination may be provided beyond the hourly ~~skilled psychosocial~~ treatment service
173.2 hours allowable per week. If clinically indicated on the client's treatment plan, this service
173.3 may be provided in conjunction with room and board according to section 254B.05,
173.4 subdivision 1a.

173.5 (4) For ASAM level 2.5 partial hospitalization clients, adults must receive 20 hours or
173.6 more of ~~skilled psychosocial~~ treatment services. Services must be licensed according to
173.7 section 245G.20 ~~and must meet requirements under section 256B.0759.~~ Level 2.5 is for
173.8 clients who need daily monitoring in a structured setting, as directed by the individual

132.5 treatment plan and in accordance with the limitations in section 254B.05, subdivision 5,
132.6 paragraph (h). If clinically indicated on the client's treatment plan, this service may be
132.7 provided in conjunction with room and board according to section 254B.05, subdivision
132.8 1a.

132.9 (5) For ASAM level 3.1 clinically managed low-intensity residential clients, programs
132.10 must provide at least 5 hours of ~~skilled psychosocial~~ treatment services per week according
132.11 to each client's specific treatment schedule, as directed by the individual treatment plan.
132.12 Programs must be licensed according to section 245G.20 and must meet requirements under
132.13 section 256B.0759.

132.14 (6) For ASAM level 3.3 clinically managed population-specific high-intensity residential
132.15 clients, programs must be licensed according to section 245G.20 and must meet requirements
132.16 under section 256B.0759. Programs must have 24-hour staffing coverage. Programs must
132.17 be enrolled as a disability responsive program as described in section 254B.01, subdivision
132.18 4b, and must specialize in serving persons with a traumatic brain injury or a cognitive
132.19 impairment so significant, and the resulting level of impairment so great, that outpatient or
132.20 other levels of residential care would not be feasible or effective. Programs must provide,
132.21 at a minimum, daily ~~skilled psychosocial~~ treatment services seven days a week according
132.22 to each client's specific treatment schedule, as directed by the individual treatment plan.

132.23 (7) For ASAM level 3.5 clinically managed high-intensity residential clients, services
132.24 must be licensed according to section 245G.20 and must meet requirements under section
132.25 256B.0759. Programs must have 24-hour staffing coverage and provide, at a minimum,
132.26 daily ~~skilled psychosocial~~ treatment services seven days a week according to each client's
132.27 specific treatment schedule, as directed by the individual treatment plan.

132.28 (8) For ASAM level withdrawal management 3.2 clinically managed clients, withdrawal
132.29 management must be provided according to chapter 245F.

132.30 (9) For ASAM level withdrawal management 3.7 medically monitored clients, withdrawal
132.31 management must be provided according to chapter 245F.

132.32 (b) Notwithstanding the minimum daily ~~skilled psychosocial~~ treatment service
132.33 requirements under paragraph (a), clauses (6) and (7), ASAM level 3.3 and 3.5 vendors
133.1 must provide each client at least 30 hours of treatment services per week for the period
133.2 between January 1, 2024, through June 30, 2024.

133.3 EFFECTIVE DATE. This section is effective July 1, 2026, or upon federal approval,
133.4 whichever is later. The commissioner of human services shall notify the revisor of statutes
133.5 when federal approval is obtained.

133.6 Sec. 50. [254B.21] DEFINITIONS.

133.7 Subdivision 1. Scope. For the purposes of sections 254B.21 to 254B.216, the following
133.8 terms have the meanings given.

173.9 treatment plan and in accordance with the limitations in section 254B.05, subdivision 5,
173.10 paragraph (h). If clinically indicated on the client's treatment plan, this service may be
173.11 provided in conjunction with room and board according to section 254B.05, subdivision
173.12 1a.

173.13 (5) For ASAM level 3.1 clinically managed low-intensity residential clients, programs
173.14 must provide at least 5 hours of ~~skilled psychosocial~~ treatment services per week according
173.15 to each client's specific treatment schedule, as directed by the individual treatment plan.
173.16 Programs must be licensed according to section 245G.20 and must meet requirements under
173.17 section 256B.0759.

173.18 (6) For ASAM level 3.3 clinically managed population-specific high-intensity residential
173.19 clients, programs must be licensed according to section 245G.20 and must meet requirements
173.20 under section 256B.0759. Programs must have 24-hour staffing coverage. Programs must
173.21 be enrolled as a disability responsive program as described in section 254B.01, subdivision
173.22 4b, and must specialize in serving persons with a traumatic brain injury or a cognitive
173.23 impairment so significant, and the resulting level of impairment so great, that outpatient or
173.24 other levels of residential care would not be feasible or effective. Programs must provide,
173.25 at a minimum, daily ~~skilled psychosocial~~ treatment services seven days a week according
173.26 to each client's specific treatment schedule, as directed by the individual treatment plan.

173.27 (7) For ASAM level 3.5 clinically managed high-intensity residential clients, services
173.28 must be licensed according to section 245G.20 and must meet requirements under section
173.29 256B.0759. Programs must have 24-hour staffing coverage and provide, at a minimum,
173.30 daily ~~skilled psychosocial~~ treatment services seven days a week according to each client's
173.31 specific treatment schedule, as directed by the individual treatment plan.

173.32 (8) For ASAM level withdrawal management 3.2 clinically managed clients, withdrawal
173.33 management must be provided according to chapter 245F.

174.1 (9) For ASAM level withdrawal management 3.7 medically monitored clients, withdrawal
174.2 management must be provided according to chapter 245F.

174.3 (b) Notwithstanding the minimum daily ~~skilled psychosocial~~ treatment service
174.4 requirements under paragraph (a), clauses (6) and (7), ASAM level 3.3 and 3.5 vendors
174.5 must provide each client at least 30 hours of treatment services per week for the period
174.6 between January 1, 2024, through June 30, 2024.

174.7 EFFECTIVE DATE. This section is effective July 1, 2026, or upon federal approval,
174.8 whichever is later. The commissioner of human services shall notify the revisor of statutes
174.9 when federal approval is obtained.

- 133.9 Subd. 2. **Applicant.** "Applicant" means any individual, organization, or entity who has
133.10 applied for certification of a recovery residence.
- 133.11 Subd. 3. **Certified recovery residence.** "Certified recovery residence" means a recovery
133.12 residence that has completed the application process and been approved for certification by
133.13 the commissioner.
- 133.14 Subd. 4. **Co-occurring disorders.** "Co-occurring disorders" means a diagnosis of both
133.15 a substance use disorder and a mental health disorder.
- 133.16 Subd. 5. **Operator.** "Operator" means the lawful owner or lessee of a recovery residence
133.17 or a person employed and designated by the owner or lessee of the recovery residence to
133.18 have primary responsibility for oversight of the recovery residence, including but not limited
133.19 to hiring and termination of recovery residence staff, recovery residence maintenance, and
133.20 responding to complaints being investigated by the commissioner.
- 133.21 Subd. 6. **Recovery residence.** "Recovery residence" means a type of community residence
133.22 that provides a safe, healthy, family-like, substance-free living environment that supports
133.23 individuals in recovery from substance use disorder.
- 133.24 Subd. 7. **Recovery residence registry.** "Recovery residence registry" means the list of
133.25 certified recovery residences maintained by the commissioner.
- 133.26 Subd. 8. **Resident.** "Resident" means an individual who resides in a recovery residence.
- 133.27 Subd. 9. **Staff.** "Staff" means employees, contractors, or volunteers who provide
133.28 monitoring, assistance, or other services for the use and benefit of a recovery residence and
133.29 the residence's residents.
- 133.30 Subd. 10. **Substance free.** "Substance free" means being free from the use of alcohol,
133.31 illicit drugs, and the illicit use of prescribed drugs. This term does not prohibit medications
133.32 prescribed, dispensed, or administered by a licensed health care professional, such as
134.1 pharmacotherapies specifically approved by the United States Food and Drug Administration
134.2 (FDA) for treatment of a substance use disorder as well as other medications approved by
134.3 the FDA for the treatment of co-occurring disorders when taken as directed.
- 134.4 Subd. 11. **Substance use disorder.** "Substance use disorder" has the meaning given in
134.5 the most recent edition of the Diagnostic and Statistical Manual of Disorders of the American
134.6 Psychiatric Association.
- 134.7 **EFFECTIVE DATE.** This section is effective January 1, 2027.
- 134.8 Sec. 51. **[254B.211] RESIDENCE REQUIREMENTS AND RESIDENT RIGHTS.**
- 134.9 Subdivision 1. **Applicability.** This section is applicable to all recovery residences
134.10 regardless of certification status.
- 134.11 Subd. 2. **Residence requirements.** All recovery residences must:

- 134.12 (1) comply with applicable state laws and regulations and local ordinances related to
134.13 maximum occupancy, fire safety, and sanitation;
- 134.14 (2) have safety policies and procedures that, at a minimum, address:
- 134.15 (i) safety inspections requiring periodic verification of smoke detectors, carbon monoxide
134.16 detectors, fire extinguishers, and emergency evacuation drills;
- 134.17 (ii) exposure to bodily fluids and contagious disease; and
- 134.18 (iii) emergency procedures posted in conspicuous locations in the residence;
- 134.19 (3) maintain a supply of an opiate antagonist in the home, post information on proper
134.20 use, and train staff in opiate antagonist use;
- 134.21 (4) have written policies regarding access to all prescribed medications and storage of
134.22 medications when requested by the resident;
- 134.23 (5) have written policies regarding residency termination, including how length of stay
134.24 is determined and procedures in case of evictions;
- 134.25 (6) return all property and medications to a person discharged from the home and retain
134.26 the items for a minimum of 60 days if the person did not collect the items upon discharge.
134.27 The owner must make an effort to contact persons listed as emergency contacts for the
134.28 discharged person so that the items are returned;
- 134.29 (7) ensure separation of money of persons served by the program from money of the
134.30 program or program staff. The program and staff must not:
- 135.1 (i) borrow money from a person served by the program;
- 135.2 (ii) purchase personal items from a person served by the program;
- 135.3 (iii) sell merchandise or personal services to a person served by the program;
- 135.4 (iv) require a person served by the program to purchase items for which the program is
135.5 eligible for reimbursement; or
- 135.6 (v) use money of persons served by the program to purchase items for which the program
135.7 is already receiving public or private payments;
- 135.8 (8) document the names and contact information for persons to contact in case of an
135.9 emergency, upon discharge, or other circumstances designated by the resident, including
135.10 but not limited to death due to an overdose;
- 135.11 (9) maintain contact information for emergency resources in the community, including
135.12 but not limited to local mental health crisis services and the 988 Lifeline, to address mental
135.13 health and health emergencies;

135.14 (10) have policies on staff qualifications and a prohibition against relationships between
135.15 operators and residents;

135.16 (11) permit residents to use, as directed by a licensed prescriber, legally prescribed and
135.17 dispensed or administered pharmacotherapies approved by the FDA for the treatment of
135.18 opioid use disorder, co-occurring substance use disorders, and mental health conditions;

135.19 (12) have a fee schedule and refund policy;

135.20 (13) have rules for residents, including on prohibited items;

135.21 (14) have policies that promote resident participation in treatment, self-help groups, or
135.22 other recovery supports;

135.23 (15) have policies requiring abstinence from alcohol and illicit drugs on the property.
135.24 If the program utilizes drug screening or toxicology, the procedures must be included in the
135.25 program's policies;

135.26 (16) distribute the recovery resident bill of rights in subdivision 3, resident rules,
135.27 certification, and grievance process and post the documents in this clause in common areas;

135.28 (17) have policies and procedures on person and room searches;

135.29 (18) have code of ethics policies and procedures they are aligned with the NARR code
135.30 of ethics and document that the policies and procedures are read and signed by all those
136.1 associated with the operation of the recovery residence, including owners, operators, staff,
136.2 and volunteers;

136.3 (19) have a description of how residents are involved with the governance of the
136.4 residence, including decision-making procedures, how residents are involved in setting and
136.5 implementing rules, and the role of peer leaders, if any; and

136.6 (20) have procedures to maintain a respectful environment, including appropriate action
136.7 to stop intimidation, bullying, sexual harassment, or threatening behavior of residents, staff,
136.8 and visitors within the residence. Programs should consider trauma-informed and
136.9 resilience-promoting practices when determining action.

136.10 Subd. 3. **Resident bill of rights.** An individual living in a recovery residence has the
136.11 right to:

136.12 (1) have access to an environment that supports recovery;

136.13 (2) have access to an environment that is safe and free from alcohol and other illicit
136.14 drugs or substances;

136.15 (3) be free from physical and verbal abuse, neglect, financial exploitation, and all forms
136.16 of maltreatment covered under the Vulnerable Adults Act, sections 626.557 to 626.5572;

136.17 (4) be treated with dignity and respect and to have personal property treated with respect;

136.18 (5) have personal, financial, and medical information kept private and to be advised of
136.19 the recovery residence's policies and procedures regarding disclosure of the information;

136.20 (6) access while living in the residence to other community-based support services as
136.21 needed;

136.22 (7) be referred to appropriate services upon leaving the residence if necessary;

136.23 (8) retain personal property that does not jeopardize the safety or health of the resident
136.24 or others;

136.25 (9) assert the rights in this subdivision personally or have the rights asserted by the
136.26 individual's representative or by anyone on behalf of the individual without retaliation;

136.27 (10) be provided with the name, address, and telephone number of the ombudsman for
136.28 mental health and developmental disabilities and the commissioner and be provided with
136.29 information about the right to file a complaint;

136.30 (11) be fully informed of the rights and responsibilities in this section and program
136.31 policies and procedures; and

137.1 (12) not be required to perform services for the residence that are not included in the
137.2 usual expectations for all residents.

137.3 **EFFECTIVE DATE.** This section is effective January 1, 2027.

137.4 Sec. 52. **[254B.212] COMPLAINTS AGAINST RECOVERY RESIDENCES.**

137.5 Subdivision 1. **In general.** Any complaints about a recovery residence may be made to
137.6 and reviewed or investigated by the commissioner.

137.7 Subd. 2. **Types of complaints.** The commissioner must receive and review complaints
137.8 that concern:

137.9 (1) the health and safety of residents;

137.10 (2) management of the recovery residence, including but not limited to house
137.11 environment, financial procedures, staffing, house rules and regulations, improper handling
137.12 of resident terminations, and recovery support environment; or

137.13 (3) illegal activities or threats.

137.14 Subd. 3. **Investigation.** (a) Complaints regarding illegal activities or threats must be
137.15 immediately referred to law enforcement in the jurisdiction where the recovery residence
137.16 is located. The commissioner must continue to investigate complaints under subdivision 2,
137.17 clause (3), that have been referred to law enforcement unless law enforcement requests the
137.18 commissioner to stay the investigation.

137.19 (b) The commissioner must investigate all other types of complaints under this section
137.20 and may take any action necessary to conduct an investigation, including but not limited to
137.21 interviewing the recovery residence operator, staff, and residents and inspecting the premises.

137.22 Subd. 4. **Anonymity.** When making a complaint pursuant to this section, an individual
137.23 must disclose the individual's identity to the commissioner. Unless ordered by a court or
137.24 authorized by the complainant, the commissioner must not disclose the complainant's
137.25 identity.

137.26 Subd. 5. **Prohibition against retaliation.** A recovery residence owner, operator, director,
137.27 staff member, or resident must not be subject to retaliation, including but not limited to
137.28 interference, threats, coercion, harassment, or discrimination for making any complaint
137.29 against a recovery residence or against a recovery residence owner, operator, or chief
137.30 financial officer.

137.31 **EFFECTIVE DATE.** This section is effective January 1, 2027.

138.1 Sec. 53. **[254B.213] CERTIFICATION.**

138.2 Subdivision 1. **Voluntary certification.** The commissioner must establish and provide
138.3 for the administration of a voluntary certification program based on best practices as outlined
138.4 by the American Society for Addiction Medicine and the Substance Abuse and Mental
138.5 Health Services Administration for recovery residences seeking certification under this
138.6 section.

138.7 Subd. 2. **Application requirements.** An applicant for certification must, at a minimum,
138.8 submit the following documents on forms approved by the commissioner:

138.9 (1) if the premises for the recovery residence is leased, documentation from the owner
138.10 that the applicant has permission from the owner to operate a recovery residence on the
138.11 premises;

138.12 (2) all policies and procedures required under this chapter;

138.13 (3) copies of all forms provided to residents, including but not limited to the recovery
138.14 residence's medication, drug-testing, return-to-use, refund, and eviction or transfer policies;

138.15 (4) proof of insurance coverage necessary and, at a minimum:

138.16 (i) employee dishonesty insurance in the amount of \$10,000 if the vendor has or had
138.17 custody or control of money or property belonging to clients; and

138.18 (ii) bodily injury and property damage insurance in the amount of \$2,000,000 for each
138.19 occurrence; and

138.20 (5) proof of completed background checks for the operator and residence staff.

138.21 Subd. 3. **Inspection pursuant to application.** Upon receiving a completed application,
138.22 the commissioner must conduct an initial on-site inspection of the recovery residence to
138.23 ensure the residence is in compliance with the requirements of sections 254B.21 to 254B.216.

138.24 Subd. 4. **Certification.** The commissioner must certify a recovery residence upon
138.25 approval of the application and after the initial on-site inspection. The certification
138.26 automatically terminates three years after issuance of the certification if the commissioner
138.27 does not renew the certification. Upon certification, the commissioner must issue the recovery
138.28 residence a proof of certification.

138.29 Subd. 5. **Display of proof of certification.** A certified recovery residence must publicly
138.30 display a proof of certification in the recovery residence.

139.1 Subd. 6. **Nontransferability.** Certifications issued pursuant to this section cannot be
139.2 transferred to an address other than the address in the application or to another certification
139.3 holder without prior approval from the commissioner.

139.4 **EFFECTIVE DATE.** This section is effective January 1, 2027.

139.5 Sec. 54. **[254B.214] MONITORING AND OVERSIGHT OF CERTIFIED**
139.6 **RECOVERY RESIDENCES.**

139.7 Subdivision 1. **Monitoring and inspections.** (a) The commissioner must conduct an
139.8 on-site certification review of the certified recovery residence every three years to determine
139.9 the certification holder's compliance with applicable rules and statutes.

139.10 (b) The commissioner must offer the certification holder a choice of dates for an
139.11 announced certification review. A certification review must occur during regular business
139.12 hours.

139.13 (c) The commissioner must make the results of certification reviews and the results of
139.14 investigations that result in a correction order publicly available on the department's website.

139.15 Subd. 2. **Commissioner's right of access.** (a) When the commissioner is exercising the
139.16 powers conferred to the commissioner under this section, if the recovery residence is in
139.17 operation and the information is relevant to the commissioner's inspection or investigation,
139.18 the certification holder must provide the commissioner access to:

139.19 (1) the physical facility and grounds where the residence is located;

139.20 (2) documentation and records, including electronically maintained records;

139.21 (3) residents served by the recovery residence;

139.22 (4) staff persons of the recovery residence; and

139.23 (5) personnel records of current and former staff of the recovery residence.

139.24 (b) The applicant or certification holder must provide the commissioner with access to
139.25 the facility and grounds, documentation and records, residents, and staff without prior notice

139.26 and as often as the commissioner considers necessary if the commissioner is conducting an
139.27 inspection or investigating alleged maltreatment or a violation of a law or rule. When
139.28 conducting an inspection, the commissioner may request assistance from other state, county,
139.29 and municipal governmental agencies and departments. The applicant or certification holder
139.30 must allow the commissioner, at the commissioner's expense, to photocopy, photograph,
139.31 and make audio and video recordings during an inspection.

140.1 Subd. 3. **Correction orders.** (a) If the applicant or certification holder fails to comply
140.2 with a law or rule, the commissioner may issue a correction order. The correction order
140.3 must state:

- 140.4 (1) the condition that constitutes a violation of the law or rule;
140.5 (2) the specific law or rule that the applicant or certification holder has violated; and
140.6 (3) the time that the applicant or certification holder is allowed to correct each violation.

140.7 (b) If the applicant or certification holder believes that the commissioner's correction
140.8 order is erroneous, the applicant or certification holder may ask the commissioner to
140.9 reconsider the correction order. An applicant or certification holder must make a request
140.10 for reconsideration in writing. The request must be sent via electronic communication to
140.11 the commissioner within 20 calendar days after the applicant or certification holder received
140.12 the correction order and must:

- 140.13 (1) specify the part of the correction order that is allegedly erroneous;
140.14 (2) explain why the specified part is erroneous; and
140.15 (3) include documentation to support the allegation of error.

140.16 (c) A request for reconsideration does not stay any provision or requirement of the
140.17 correction order. The commissioner's disposition of a request for reconsideration is final
140.18 and not subject to appeal.

140.19 (d) If the commissioner finds that the applicant or certification holder failed to correct
140.20 the violation specified in the correction order, the commissioner may decertify the certified
140.21 recovery residence according to subdivision 4.

140.22 (e) Nothing in this subdivision prohibits the commissioner from decertifying a recovery
140.23 residence according to subdivision 4.

140.24 Subd. 4. **Decertification.** (a) The commissioner may decertify a recovery residence if
140.25 a certification holder:

- 140.26 (1) failed to comply with an applicable law or rule; or

140.27 (2) knowingly withheld relevant information from or gave false or misleading information
140.28 to the commissioner in connection with an application for certification, during an
140.29 investigation, or regarding compliance with applicable laws or rules.

141.1 (b) When considering decertification of a recovery residence, the commissioner must
141.2 consider the nature, chronicity, or severity of the violation of law or rule and the effect of
141.3 the violation on the health, safety, or rights of residents.

141.4 (c) If the commissioner decertifies a recovery residence, the order of decertification
141.5 must inform the certification holder of the right to have a contested case hearing under
141.6 chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The certification holder
141.7 may appeal the decertification. The certification holder must appeal a decertification in
141.8 writing and send or deliver the appeal to the commissioner by certified mail or personal
141.9 service. If the certification holder mails the appeal, the appeal must be postmarked and sent
141.10 to the commissioner within ten calendar days after the certification holder receives the order
141.11 of decertification. If the certification holder delivers an appeal by personal service, the
141.12 commissioner must receive the appeal within ten calendar days after the certification holder
141.13 received the order. If the certification holder submits a timely appeal of an order of
141.14 decertification, the certification holder may continue to operate the program until the
141.15 commissioner issues a final order on the decertification.

141.16 (d) If the commissioner decertifies a recovery residence pursuant to paragraph (a), clause
141.17 (1), based on a determination that the recovery residence was responsible for maltreatment
141.18 under chapter 260E or section 626.557, the final decertification determination is stayed until
141.19 the commissioner issues a final decision regarding the maltreatment appeal if the certification
141.20 holder appeals the decertification according to paragraph (c) and appeals the maltreatment
141.21 determination pursuant to chapter 260E or section 626.557.

141.22 Subd. 5. **Notifications required and noncompliance.** (a) Changes in recovery residence
141.23 organization, staffing, services, or quality assurance procedures that affect the ability of the
141.24 certification holder to comply with the minimum standards of this chapter must be reported
141.25 in writing by the certification holder to the commissioner, in a manner approved by the
141.26 commissioner, within 15 days of the occurrence. The commissioner must review the change.
141.27 If the change would result in noncompliance in minimum standards, the commissioner must
141.28 give the recovery residence written notice and up to 180 days to correct the areas of
141.29 noncompliance before being decertified. The recovery residence must develop interim
141.30 procedures to resolve the noncompliance on a temporary basis and submit the interim
141.31 procedures in writing to the commissioner for approval within 30 days of the commissioner's
141.32 determination of the noncompliance. The commissioner must immediately decertify a
141.33 recovery residence that fails to report a change that results in noncompliance within 15 days,
141.34 fails to develop an approved interim procedure within 30 days of the determination of the
141.35 noncompliance, or does not resolve the noncompliance within 180 days.

142.1 (b) The commissioner may require the recovery residence to submit written information
142.2 to document that the recovery residence has maintained compliance with this section.

142.3 **EFFECTIVE DATE.** This section is effective January 1, 2027.

142.4 Sec. 55. **[254B.215] CERTIFICATION LEVELS.**

142.5 Subdivision 1. **Certification levels.** When certifying a recovery residence, the
142.6 commissioner must specify whether the residence is a level-one or level-two certified
142.7 recovery residence.

142.8 Subd. 2. **Level-one certification.** (a) The commissioner must designate a certified
142.9 residence as a level-one certified recovery residence when the residence is peer run. A
142.10 level-one certified recovery residence must:

142.11 (1) not permit an allowance for on-site paid staff or operator of the recovery residence;

142.12 (2) permit only nonpaid staff to live or work within the residence; and

142.13 (3) ensure that decisions are made solely by residents.

142.14 (b) Staff of a level-one certified recovery residence must not provide billable peer
142.15 recovery support services to residents of the recovery residence.

142.16 Subd. 3. **Level-two certification.** (a) The commissioner must designate a certified
142.17 residence as a level-two certified recovery residence when the residence is managed by
142.18 someone other than the residents. A level-two certified recovery residence must have staff
142.19 to model and teach recovery skills and behaviors.

142.20 (b) A level-two certified recovery residence must:

142.21 (1) have written job descriptions for each staff member position, including position
142.22 responsibilities and qualifications;

142.23 (2) have written policies and procedures for ongoing performance development of staff;

142.24 (3) provide annual training on emergency procedures, resident bill of rights, grievance
142.25 policies and procedures, and code of ethics;

142.26 (4) provide community or house meetings, peer supports, and involvement in self-help
142.27 or off-site treatment services;

142.28 (5) have identified recovery goals;

142.29 (6) maintain documentation that residents are linked with community resources such as
142.30 job search, education, family services, and health and housing programs; and

143.1 (7) maintain documentation of referrals made for additional services.

143.2 (c) Staff of a level-two certified recovery residence must not provide billable peer support
143.3 services to residents of the recovery residence.

143.4 **EFFECTIVE DATE.** This section is effective January 1, 2027.

143.5 Sec. 56. [254B.216] RESIDENT RECORD.

143.6 A certified recovery residence must maintain documentation with a resident's signature

143.7 stating that each resident received the following prior to or on the first day of residency:

143.8 (1) the recovery resident bill of rights in section 254B.211, subdivision 3;

143.9 (2) the residence's financial obligations and agreements, refund policy, and payments

143.10 from third-party payers for any fees paid on the resident's behalf;

143.11 (3) a description of the services provided by the recovery residence;

143.12 (4) relapse policies;

143.13 (5) policies regarding personal property;

143.14 (6) orientation to emergency procedures;

143.15 (7) orientation to resident rules; and

143.16 (8) all other applicable orientation materials identified in sections 254B.21 to 254B.216.

143.17 EFFECTIVE DATE. This section is effective January 1, 2027.

143.18 Sec. 57. Minnesota Statutes 2024, section 256.043, subdivision 3, is amended to read:

143.19 Subd. 3. **Appropriations from registration and license fee account.** (a) The

143.20 appropriations in paragraphs (b) to (n) shall be made from the registration and license fee

143.21 account on a fiscal year basis in the order specified.

174.10 Sec. 27. Minnesota Statutes 2024, section 256.042, subdivision 4, is amended to read:

174.11 Subd. 4. **Grants.** (a) The commissioner of human services shall submit a report of the

174.12 grants proposed by the advisory council to be awarded for the upcoming calendar year to

174.13 the chairs and ranking minority members of the legislative committees with jurisdiction

174.14 over health and human services policy and finance, by December 1 of each year, beginning

174.15 December 1, 2022. This paragraph expires upon the expiration of the advisory council.

174.16 (b) The grants shall be awarded to proposals selected by the advisory council that address

174.17 the priorities in subdivision 1, paragraph (a), clauses (1) to (4), unless otherwise appropriated

174.18 by the legislature. The advisory council shall determine grant awards and funding amounts

174.19 based on the funds appropriated to the commissioner under section 256.043, subdivision 3,

174.20 paragraph ~~(n)~~ (m), and subdivision 3a, paragraph (d). The commissioner shall award the

174.21 grants from the opiate epidemic response fund and administer the grants in compliance with

174.22 section 16B.97. No more than ten percent of the grant amount may be used by a grantee for

174.23 administration.

174.24 EFFECTIVE DATE. This section is effective the day following final enactment or

174.25 retroactively from June 30, 2025, whichever is earlier.

174.26 Sec. 28. Minnesota Statutes 2024, section 256.043, subdivision 3, is amended to read:

174.27 Subd. 3. **Appropriations from registration and license fee account.** (a) The

174.28 appropriations in paragraphs (b) to ~~(n)~~ (m) shall be made from the registration and license

174.29 fee account on a fiscal year basis in the order specified.

143.22 (b) The appropriations specified in Laws 2019, chapter 63, article 3, section 1, paragraphs
 143.23 (b), (f), (g), and (h), as amended by Laws 2020, chapter 115, article 3, section 35, shall be
 143.24 made accordingly.

143.25 (c) \$100,000 is appropriated to the commissioner of human services for grants for opiate
 143.26 antagonist distribution. Grantees may utilize funds for opioid overdose prevention,
 143.27 community asset mapping, education, and opiate antagonist distribution.

143.28 (d) \$2,000,000 is appropriated to the commissioner of human services for grants direct
 143.29 payments to Tribal nations and five urban Indian communities for traditional healing practices
 144.1 for American Indians and to increase the capacity of culturally specific providers in the
 144.2 behavioral health workforce. Any evaluations of practices under this paragraph must be
 144.3 designed cooperatively by the commissioner and Tribal nations or urban Indian communities.
 144.4 The commissioner must not require recipients to provide the details of specific ceremonies
 144.5 or identities of healers.

144.6 (e) \$400,000 is appropriated to the commissioner of human services for competitive
 144.7 grants for opioid-focused Project ECHO programs.

144.8 (f) \$277,000 in fiscal year 2024 and \$321,000 each year thereafter is appropriated to the
 144.9 commissioner of human services to administer the funding distribution and reporting
 144.10 requirements in paragraph (o).

144.11 (g) \$3,000,000 in fiscal year 2025 and \$3,000,000 each year thereafter is appropriated
 144.12 to the commissioner of human services for safe recovery sites start-up and capacity building
 144.13 grants under section 254B.18.

144.14 (h) \$395,000 in fiscal year 2024 and \$415,000 each year thereafter is appropriated to
 144.15 the commissioner of human services for the opioid overdose surge alert system under section
 144.16 245.891.

144.17 (i) \$300,000 is appropriated to the commissioner of management and budget for
 144.18 evaluation activities under section 256.042, subdivision 1, paragraph (c).

144.19 (j) \$261,000 is appropriated to the commissioner of human services for the provision of
 144.20 administrative services to the Opiate Epidemic Response Advisory Council and for the
 144.21 administration of the grants awarded under paragraph (n).

144.22 (k) \$126,000 is appropriated to the Board of Pharmacy for the collection of the registration
 144.23 fees under section 151.066.

144.24 (l) \$672,000 is appropriated to the commissioner of public safety for the Bureau of
 144.25 Criminal Apprehension. Of this amount, \$384,000 is for drug scientists and lab supplies
 144.26 and \$288,000 is for special agent positions focused on drug interdiction and drug trafficking.

144.27 (m) After the appropriations in paragraphs (b) to (l) are made, 50 percent of the remaining
 144.28 amount is appropriated to the commissioner of children, youth, and families for distribution
 144.29 to county social service agencies and Tribal social service agency initiative projects

174.30 (b) The appropriations specified in Laws 2019, chapter 63, article 3, section 1, paragraphs
 174.31 (b), (f), (g), and (h), as amended by Laws 2020, chapter 115, article 3, section 35, shall be
 174.32 made accordingly.

175.1 (c) \$100,000 is appropriated to the commissioner of human services for grants for opiate
 175.2 antagonist distribution. Grantees may utilize funds for opioid overdose prevention,
 175.3 community asset mapping, education, and opiate antagonist distribution.

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 175.5 nations and five urban Indian communities for traditional healing practices for American
 175.6 Indians and to increase the capacity of culturally specific providers in the behavioral health
 175.7 workforce.

175.8 (e) \$400,000 is appropriated to the commissioner of human services for competitive
 175.9 grants for opioid-focused Project ECHO programs.

175.10 (f) \$277,000 in fiscal year 2024 and \$321,000 each year thereafter is appropriated to the
 175.11 commissioner of human services to administer the funding distribution and reporting
 175.12 requirements in paragraph ~~(o)~~ (n).

175.13 ~~(g) \$3,000,000 in fiscal year 2025 and \$3,000,000 each year thereafter is appropriated~~
 175.14 ~~to the commissioner of human services for safe recovery sites start-up and capacity building~~
 175.15 ~~grants under section 254B.18.~~

175.16 ~~(h)~~ (g) \$395,000 in fiscal year 2024 and \$415,000 each year thereafter is appropriated
 175.17 to the commissioner of human services for the opioid overdose surge alert system under
 175.18 section 245.891.

175.19 ~~(i)~~ (h) \$300,000 is appropriated to the commissioner of management and budget for
 175.20 evaluation activities under section 256.042, subdivision 1, paragraph (c).

175.21 ~~(j)~~ (i) \$261,000 is appropriated to the commissioner of human services for the provision
 175.22 of administrative services to the Opiate Epidemic Response Advisory Council and for the
 175.23 administration of the grants awarded under paragraph ~~(n)~~ (m).

175.24 ~~(k)~~ (j) \$126,000 is appropriated to the Board of Pharmacy for the collection of the
 175.25 registration fees under section 151.066.

175.26 ~~(l)~~ (k) \$672,000 is appropriated to the commissioner of public safety for the Bureau of
 175.27 Criminal Apprehension. Of this amount, \$384,000 is for drug scientists and lab supplies
 175.28 and \$288,000 is for special agent positions focused on drug interdiction and drug trafficking.

175.29 ~~(m)~~ (l) After the appropriations in paragraphs (b) to ~~(l)~~ (k) are made, 50 percent of the
 175.30 remaining amount is appropriated to the commissioner of children, youth, and families for
 175.31 distribution to county social service agencies and Tribal social service agency initiative

144.30 authorized under section 256.01, subdivision 14b, to provide prevention and child protection
144.31 services to children and families who are affected by addiction. The commissioner shall
144.32 distribute this money proportionally to county social service agencies and Tribal social
144.33 service agency initiative projects through a formula based on intake data from the previous
145.1 three calendar years related to substance use and out-of-home placement episodes where
145.2 parental drug abuse is a reason for the out-of-home placement. County social service agencies
145.3 and Tribal social service agency initiative projects receiving funds from the opiate epidemic
145.4 response fund must annually report to the commissioner on how the funds were used to
145.5 provide prevention and child protection services, including measurable outcomes, as
145.6 determined by the commissioner. County social service agencies and Tribal social service
145.7 agency initiative projects must not use funds received under this paragraph to supplant
145.8 current state or local funding received for child protection services for children and families
145.9 who are affected by addiction.

145.10 (n) After the appropriations in paragraphs (b) to (m) are made, the remaining amount in
145.11 the account is appropriated to the commissioner of human services to award grants as
145.12 specified by the Opiate Epidemic Response Advisory Council in accordance with section
145.13 256.042, unless otherwise appropriated by the legislature.

145.14 (o) Beginning in fiscal year 2022 and each year thereafter, funds for county social service
145.15 agencies and Tribal social service agency initiative projects under paragraph (m) and grant
145.16 funds specified by the Opiate Epidemic Response Advisory Council under paragraph (n)
145.17 may be distributed on a calendar year basis.

145.18 (p) Notwithstanding section 16A.28, subdivision 3, funds appropriated in paragraphs
145.19 (c), (d), (e), (g), (m), and (n) are available for three years after the funds are appropriated.

175.32 projects authorized under section 256.01, subdivision 14b, to provide prevention and child
175.33 protection services to children and families who are affected by addiction. The commissioner
176.1 shall distribute this money proportionally to county social service agencies and Tribal social
176.2 service agency initiative projects through a formula based on intake data from the previous
176.3 three calendar years related to substance use and out-of-home placement episodes where
176.4 parental drug abuse is a reason for the out-of-home placement. County social service agencies
176.5 and Tribal social service agency initiative projects receiving funds from the opiate epidemic
176.6 response fund must annually report to the commissioner on how the funds were used to
176.7 provide prevention and child protection services, including measurable outcomes, as
176.8 determined by the commissioner. County social service agencies and Tribal social service
176.9 agency initiative projects must not use funds received under this paragraph to supplant
176.10 current state or local funding received for child protection services for children and families
176.11 who are affected by addiction.

176.12 ~~(m)~~ (l) After the appropriations in paragraphs (b) to ~~(m)~~ (l) are made, the remaining
176.13 amount in the account is appropriated to the commissioner of human services to award
176.14 grants as specified by the Opiate Epidemic Response Advisory Council in accordance with
176.15 section 256.042, unless otherwise appropriated by the legislature.

176.16 ~~(o)~~ (n) Beginning in fiscal year 2022 and each year thereafter, funds for county social
176.17 service agencies and Tribal social service agency initiative projects under paragraph ~~(m)~~
176.18 (l) and grant funds specified by the Opiate Epidemic Response Advisory Council under
176.19 paragraph ~~(m)~~ (m) may be distributed on a calendar year basis.

176.20 ~~(p)~~ (o) Notwithstanding section 16A.28, subdivision 3, funds appropriated in paragraphs
176.21 (c), (d), (e), ~~(g)~~ (h), ~~(m)~~ (l), and ~~(n)~~ (m) are available for three years after the funds are
176.22 appropriated.

176.23 **EFFECTIVE DATE.** This section is effective the day following final enactment or
176.24 retroactively from June 30, 2025, whichever is earlier.

176.25 Sec. 29. Minnesota Statutes 2024, section 256.043, subdivision 3a, is amended to read:

176.26 Subd. 3a. **Appropriations from settlement account.** (a) The appropriations in paragraphs
176.27 (b) to (e) shall be made from the settlement account on a fiscal year basis in the order
176.28 specified.

176.29 (b) If the balance in the registration and license fee account is not sufficient to fully fund
176.30 the appropriations specified in subdivision 3, paragraphs (b) to ~~(h)~~ (k), an amount necessary
176.31 to meet any insufficiency shall be transferred from the settlement account to the registration
176.32 and license fee account to fully fund the required appropriations.

177.1 (c) \$209,000 in fiscal year 2023 and \$239,000 in fiscal year 2024 and subsequent fiscal
177.2 years are appropriated to the commissioner of human services for the administration of
177.3 grants awarded under paragraph (e). \$276,000 in fiscal year 2023 and \$151,000 in fiscal
177.4 year 2024 and subsequent fiscal years are appropriated to the commissioner of human
177.5 services to collect, collate, and report data submitted and to monitor compliance with

145.20 Sec. 58. Minnesota Statutes 2024, section 256B.0625, subdivision 5m, is amended to read:

145.21 Subd. 5m. **Certified community behavioral health clinic services.** (a) Medical
145.22 assistance covers services provided by a not-for-profit certified community behavioral health
145.23 clinic (CCBHC) that meets the requirements of section 245.735, subdivision 3.

145.24 (b) The commissioner shall reimburse CCBHCs on a per-day basis for each day that an
145.25 eligible service is delivered using the CCBHC daily bundled rate system for medical
145.26 assistance payments as described in paragraph (c). The commissioner shall include a quality
145.27 incentive payment in the CCBHC daily bundled rate system as described in paragraph (e).
145.28 There is no county share for medical assistance services when reimbursed through the
145.29 CCBHC daily bundled rate system.

145.30 (c) The commissioner shall ensure that the CCBHC daily bundled rate system for CCBHC
145.31 payments under medical assistance meets the following requirements:

145.32 (1) the CCBHC daily bundled rate shall be a provider-specific rate calculated for each
145.33 CCBHC, based on the daily cost of providing CCBHC services and the total annual allowable
146.1 CCBHC costs divided by the total annual number of CCBHC visits. For calculating the
146.2 payment rate, total annual visits include visits covered by medical assistance and visits not

177.6 reporting and settlement expenditure requirements by grantees awarded grants under this
177.7 section and municipalities receiving direct payments from a statewide opioid settlement
177.8 agreement as defined in section 256.042, subdivision 6.

177.9 (d) After any appropriations necessary under paragraphs (b) and (c) are made, an amount
177.10 equal to the calendar year allocation to Tribal social service agency initiative projects under
177.11 subdivision 3, paragraph ~~(m)~~ (l), is appropriated from the settlement account to the
177.12 commissioner of children, youth, and families for distribution to Tribal social service agency
177.13 initiative projects to provide child protection services to children and families who are
177.14 affected by addiction. The requirements related to proportional distribution, annual reporting,
177.15 and maintenance of effort specified in subdivision 3, paragraph ~~(m)~~ (l), also apply to the
177.16 appropriations made under this paragraph.

177.17 (e) After making the appropriations in paragraphs (b), (c), and (d), the remaining amount
177.18 in the account is appropriated to the commissioner of human services to award grants as
177.19 specified by the Opiate Epidemic Response Advisory Council in accordance with section
177.20 256.042.

177.21 (f) Funds for Tribal social service agency initiative projects under paragraph (d) and
177.22 grant funds specified by the Opiate Epidemic Response Advisory Council under paragraph
177.23 (e) may be distributed on a calendar year basis.

177.24 (g) Notwithstanding section 16A.28, subdivision 3, funds appropriated in paragraphs
177.25 (d) and (e) are available for three years after the funds are appropriated.

177.26 **EFFECTIVE DATE.** This section is effective the day following final enactment or
177.27 retroactively from June 30, 2025, whichever is earlier.

177.28 Sec. 30. Minnesota Statutes 2024, section 256B.0625, subdivision 5m, is amended to read:

177.29 Subd. 5m. **Certified community behavioral health clinic services.** (a) Medical
177.30 assistance covers services provided by a not-for-profit certified community behavioral health
177.31 clinic (CCBHC) that meets the requirements of section 245.735, subdivision 3.

177.32 (b) The commissioner shall reimburse CCBHCs on a per-day basis for each day that an
177.33 eligible service is delivered using the CCBHC daily bundled rate system for medical
178.1 assistance payments as described in paragraph (c). The commissioner shall include a quality
178.2 incentive payment in the CCBHC daily bundled rate system as described in paragraph (e).
178.3 There is no county share for medical assistance services when reimbursed through the
178.4 CCBHC daily bundled rate system.

178.5 (c) The commissioner shall ensure that the CCBHC daily bundled rate system for CCBHC
178.6 payments under medical assistance meets the following requirements:

178.7 (1) the CCBHC daily bundled rate shall be a provider-specific rate calculated for each
178.8 CCBHC, based on the daily cost of providing CCBHC services and the total annual allowable
178.9 CCBHC costs divided by the total annual number of CCBHC visits. For calculating the
178.10 payment rate, total annual visits include visits covered by medical assistance and visits not

146.3 covered by medical assistance. Allowable costs include but are not limited to the salaries
146.4 and benefits of medical assistance providers; the cost of CCBHC services provided under
146.5 section 245.735, subdivision 3, paragraph (a), clauses (6) and (7); and other costs such as
146.6 insurance or supplies needed to provide CCBHC services;

146.7 (2) payment shall be limited to one payment per day per medical assistance enrollee
146.8 when an eligible CCBHC service is provided. A CCBHC visit is eligible for reimbursement
146.9 if at least one of the CCBHC services listed under section 245.735, subdivision 3, paragraph
146.10 (a), clause (6), is furnished to a medical assistance enrollee by a health care practitioner or
146.11 licensed agency employed by or under contract with a CCBHC;

146.12 (3) initial CCBHC daily bundled rates for newly certified CCBHCs under section 245.735,
146.13 subdivision 3, shall be established by the commissioner using a provider-specific rate based
146.14 on the newly certified CCBHC's audited historical cost report data adjusted for the expected
146.15 cost of delivering CCBHC services. Estimates are subject to review by the commissioner
146.16 and must include the expected cost of providing the full scope of CCBHC services and the
146.17 expected number of visits for the rate period;

146.18 (4) the commissioner shall rebase CCBHC rates once every two years following the last
146.19 rebasing and no less than 12 months following an initial rate or a rate change due to a change
146.20 in the scope of services. For CCBHCs certified after September 31, 2020, and before January
146.21 1, 2021, the commissioner shall rebase rates according to this clause for services provided
146.22 on or after January 1, 2024;

146.23 (5) the commissioner shall provide for a 60-day appeals process after notice of the results
146.24 of the rebasing;

146.25 (6) an entity that receives a CCBHC daily bundled rate that overlaps with another federal
146.26 Medicaid rate is not eligible for the CCBHC rate methodology;

146.27 (7) payments for CCBHC services to individuals enrolled in managed care shall be
146.28 coordinated with the state's phase-out of CCBHC wrap payments. The commissioner shall
146.29 complete the phase-out of CCBHC wrap payments within 60 days of the implementation
146.30 of the CCBHC daily bundled rate system in the Medicaid Management Information System
146.31 (MMIS), for CCBHCs reimbursed under this chapter, with a final settlement of payments
146.32 due made payable to CCBHCs no later than 18 months thereafter;

146.33 (8) the CCBHC daily bundled rate for each CCBHC shall be updated by trending each
146.34 provider-specific rate by the Medicare Economic Index for primary care services. This
147.1 update shall occur each year in between rebasing periods determined by the commissioner
147.2 in accordance with clause (4). CCBHCs must provide data on costs and visits to the state
147.3 annually using the CCBHC cost report established by the commissioner; and

147.4 (9) a CCBHC may request a rate adjustment for changes in the CCBHC's scope of
147.5 services when such changes are expected to result in an adjustment to the CCBHC payment
147.6 rate by 2.5 percent or more. The CCBHC must provide the commissioner with information
147.7 regarding the changes in the scope of services, including the estimated cost of providing

178.11 covered by medical assistance. Allowable costs include but are not limited to the salaries
178.12 and benefits of medical assistance providers; the cost of CCBHC services provided under
178.13 section 245.735, subdivision 3, paragraph (a), clauses (6) and (7); and other costs such as
178.14 insurance or supplies needed to provide CCBHC services;

178.15 (2) payment shall be limited to one payment per day per medical assistance enrollee
178.16 when an eligible CCBHC service is provided. A CCBHC visit is eligible for reimbursement
178.17 if at least one of the CCBHC services listed under section 245.735, subdivision 3, paragraph
178.18 (a), clause (6), is furnished to a medical assistance enrollee by a health care practitioner or
178.19 licensed agency employed by or under contract with a CCBHC;

178.20 (3) initial CCBHC daily bundled rates for newly certified CCBHCs under section 245.735,
178.21 subdivision 3, shall be established by the commissioner using a provider-specific rate based
178.22 on the newly certified CCBHC's audited historical cost report data adjusted for the expected
178.23 cost of delivering CCBHC services. Estimates are subject to review by the commissioner
178.24 and must include the expected cost of providing the full scope of CCBHC services and the
178.25 expected number of visits for the rate period;

178.26 (4) the commissioner shall rebase CCBHC rates once every two years following the last
178.27 rebasing and no less than 12 months following an initial rate or a rate change due to a change
178.28 in the scope of services. For CCBHCs certified after September 31, 2020, and before January
178.29 1, 2021, the commissioner shall rebase rates according to this clause for services provided
178.30 on or after January 1, 2024;

178.31 (5) the commissioner shall provide for a 60-day appeals process after notice of the results
178.32 of the rebasing;

178.33 (6) an entity that receives a CCBHC daily bundled rate that overlaps with another federal
178.34 Medicaid rate is not eligible for the CCBHC rate methodology;

179.1 (7) payments for CCBHC services to individuals enrolled in managed care shall be
179.2 coordinated with the state's phase-out of CCBHC wrap payments. The commissioner shall
179.3 complete the phase-out of CCBHC wrap payments within 60 days of the implementation
179.4 of the CCBHC daily bundled rate system in the Medicaid Management Information System
179.5 (MMIS), for CCBHCs reimbursed under this chapter, with a final settlement of payments
179.6 due made payable to CCBHCs no later than 18 months thereafter;

179.7 (8) the CCBHC daily bundled rate for each CCBHC shall be updated by trending each
179.8 provider-specific rate by the Medicare Economic Index for primary care services. This
179.9 update shall occur each year in between rebasing periods determined by the commissioner
179.10 in accordance with clause (4). CCBHCs must provide data on costs and visits to the state
179.11 annually using the CCBHC cost report established by the commissioner; and

179.12 (9) a CCBHC may request a rate adjustment for changes in the CCBHC's scope of
179.13 services when such changes are expected to result in an adjustment to the CCBHC payment
179.14 rate by 2.5 percent or more. The CCBHC must provide the commissioner with information
179.15 regarding the changes in the scope of services, including the estimated cost of providing

147.8 the new or modified services and any projected increase or decrease in the number of visits
147.9 resulting from the change. Estimated costs are subject to review by the commissioner. Rate
147.10 adjustments for changes in scope shall occur no more than once per year in between rebasing
147.11 periods per CCBHC and are effective on the date of the annual CCBHC rate update.

147.12 (d) Managed care plans and county-based purchasing plans shall reimburse CCBHC
147.13 providers at the CCBHC daily bundled rate. The commissioner shall monitor the effect of
147.14 this requirement on the rate of access to the services delivered by CCBHC providers. If, for
147.15 any contract year, federal approval is not received for this paragraph, the commissioner
147.16 must adjust the capitation rates paid to managed care plans and county-based purchasing
147.17 plans for that contract year to reflect the removal of this provision. Contracts between
147.18 managed care plans and county-based purchasing plans and providers to whom this paragraph
147.19 applies must allow recovery of payments from those providers if capitation rates are adjusted
147.20 in accordance with this paragraph. Payment recoveries must not exceed the amount equal
147.21 to any increase in rates that results from this provision. This paragraph expires if federal
147.22 approval is not received for this paragraph at any time.

147.23 (e) The commissioner shall implement a quality incentive payment program for CCBHCs
147.24 that meets the following requirements:

147.25 (1) a CCBHC shall receive a quality incentive payment upon meeting specific numeric
147.26 thresholds for performance metrics established by the commissioner, in addition to payments
147.27 for which the CCBHC is eligible under the CCBHC daily bundled rate system described in
147.28 paragraph (c);

147.29 (2) a CCBHC must be certified and enrolled as a CCBHC for the entire measurement
147.30 year to be eligible for incentive payments;

147.31 (3) each CCBHC shall receive written notice of the criteria that must be met in order to
147.32 receive quality incentive payments at least 90 days prior to the measurement year; and

147.33 (4) a CCBHC must provide the commissioner with data needed to determine incentive
147.34 payment eligibility within six months following the measurement year. The commissioner
148.1 shall notify CCBHC providers of their performance on the required measures and the
148.2 incentive payment amount within 12 months following the measurement year.

148.3 (f) All claims to managed care plans for CCBHC services as provided under this section
148.4 shall be submitted directly to, and paid by, the commissioner on the dates specified no later
148.5 than January 1 of the following calendar year, if:

148.6 (1) one or more managed care plans does not comply with the federal requirement for
148.7 payment of clean claims to CCBHCs, as defined in Code of Federal Regulations, title 42,
148.8 section 447.45(b), and the managed care plan does not resolve the payment issue within 30
148.9 days of noncompliance; and

179.16 the new or modified services and any projected increase or decrease in the number of visits
179.17 resulting from the change. Estimated costs are subject to review by the commissioner. Rate
179.18 adjustments for changes in scope shall occur no more than once per year in between rebasing
179.19 periods per CCBHC and are effective on the date of the annual CCBHC rate update.

179.20 (d) Managed care plans and county-based purchasing plans shall reimburse CCBHC
179.21 providers at the CCBHC daily bundled rate. The commissioner shall monitor the effect of
179.22 this requirement on the rate of access to the services delivered by CCBHC providers. If, for
179.23 any contract year, federal approval is not received for this paragraph, the commissioner
179.24 must adjust the capitation rates paid to managed care plans and county-based purchasing
179.25 plans for that contract year to reflect the removal of this provision. Contracts between
179.26 managed care plans and county-based purchasing plans and providers to whom this paragraph
179.27 applies must allow recovery of payments from those providers if capitation rates are adjusted
179.28 in accordance with this paragraph. Payment recoveries must not exceed the amount equal
179.29 to any increase in rates that results from this provision. This paragraph expires if federal
179.30 approval is not received for this paragraph at any time.

179.31 (e) The commissioner shall implement a quality incentive payment program for CCBHCs
179.32 that meets the following requirements:

179.33 (1) a CCBHC shall receive a quality incentive payment upon meeting specific numeric
179.34 thresholds for performance metrics established by the commissioner, in addition to payments
180.1 for which the CCBHC is eligible under the CCBHC daily bundled rate system described in
180.2 paragraph (c);

180.3 (2) a CCBHC must be certified and enrolled as a CCBHC for the entire measurement
180.4 year to be eligible for incentive payments;

180.5 (3) each CCBHC shall receive written notice of the criteria that must be met in order to
180.6 receive quality incentive payments at least 90 days prior to the measurement year; and

180.7 (4) a CCBHC must provide the commissioner with data needed to determine incentive
180.8 payment eligibility within six months following the measurement year. The commissioner
180.9 shall notify CCBHC providers of their performance on the required measures and the
180.10 incentive payment amount within 12 months following the measurement year.

180.11 (f) All claims to managed care plans for CCBHC services as provided under this section
180.12 shall be submitted directly to, and paid by, the commissioner on the dates specified no later
180.13 than January 1 of the following calendar year, if:

180.14 (1) one or more managed care plans does not comply with the federal requirement for
180.15 payment of clean claims to CCBHCs, as defined in Code of Federal Regulations, title 42,
180.16 section 447.45(b), and the managed care plan does not resolve the payment issue within 30
180.17 days of noncompliance; and

148.10 (2) the total amount of clean claims not paid in accordance with federal requirements
148.11 by one or more managed care plans is 50 percent of, or greater than, the total CCBHC claims
148.12 eligible for payment by managed care plans.

148.13 If the conditions in this paragraph are met between January 1 and June 30 of a calendar
148.14 year, claims shall be submitted to and paid by the commissioner beginning on January 1 of
148.15 the following year. If the conditions in this paragraph are met between July 1 and December
148.16 31 of a calendar year, claims shall be submitted to and paid by the commissioner beginning
148.17 on July 1 of the following year.

148.18 (g) Peer services provided by a CCBHC certified under section 245.735 are a covered
148.19 service under medical assistance when a licensed mental health professional or alcohol and
148.20 drug counselor determines that peer services are medically necessary. Eligibility under this
148.21 subdivision for peer services provided by a CCBHC supersede eligibility standards under
148.22 sections 256B.0615, 256B.0616, and 245G.07, subdivision ~~2~~ 2a, paragraph (b), clause ~~(8)~~
148.23 (2).

148.24 EFFECTIVE DATE. This section is effective July 1, 2026, or upon federal approval,
148.25 whichever is later. The commissioner of human services shall notify the revisor of statutes
148.26 when federal approval is obtained.

148.27 Sec. 59. Minnesota Statutes 2024, section 256B.0625, subdivision 20, is amended to read:

148.28 Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the
148.29 state agency, medical assistance covers case management services to persons with serious
148.30 and persistent mental illness, persons with a complex post-traumatic stress disorder, and
148.31 children with severe emotional disturbance. Services provided under this section must meet
148.32 the relevant standards in sections 245.461 to 245.4887, the Comprehensive Adult and
149.1 Children's Mental Health Acts, Minnesota Rules, parts 9520.0900 to 9520.0926, and
149.2 9505.0322, excluding subpart 10.

149.3 (b) Entities meeting program standards set out in rules governing family community
149.4 support services as defined in section 245.4871, subdivision 17, are eligible for medical
149.5 assistance reimbursement for case management services for children with severe emotional
149.6 disturbance when these services meet the program standards in Minnesota Rules, parts
149.7 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

149.8 (c) Medical assistance and MinnesotaCare payment for mental health case management
149.9 shall be made on a monthly basis. In order to receive payment for an eligible child, the
149.10 provider must document at least a face-to-face contact either in person or by interactive
149.11 video that meets the requirements of subdivision 20b with the child, the child's parents, or
149.12 the child's legal representative. To receive payment for an eligible adult, the provider must
149.13 document:

180.18 (2) the total amount of clean claims not paid in accordance with federal requirements
180.19 by one or more managed care plans is 50 percent of, or greater than, the total CCBHC claims
180.20 eligible for payment by managed care plans.

180.21 If the conditions in this paragraph are met between January 1 and June 30 of a calendar
180.22 year, claims shall be submitted to and paid by the commissioner beginning on January 1 of
180.23 the following year. If the conditions in this paragraph are met between July 1 and December
180.24 31 of a calendar year, claims shall be submitted to and paid by the commissioner beginning
180.25 on July 1 of the following year.

180.26 (g) Peer services provided by a CCBHC certified under section 245.735 are a covered
180.27 service under medical assistance when a licensed mental health professional or alcohol and
180.28 drug counselor determines that peer services are medically necessary. Eligibility under this
180.29 subdivision for peer services provided by a CCBHC supersede eligibility standards under
180.30 sections 256B.0615, 256B.0616, and 245G.07, subdivision ~~2~~ 2a, paragraph (b), clause ~~(8)~~
180.31 (2).

181.1 EFFECTIVE DATE. This section is effective July 1, 2026, or upon federal approval,
181.2 whichever is later. The commissioner of human services shall notify the revisor of statutes
181.3 when federal approval is obtained.

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275.23 Sec. 13. Minnesota Statutes 2024, section 256B.0625, subdivision 20, is amended to read:

275.24 Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the
275.25 state agency, medical assistance covers case management services to persons with serious
275.26 and persistent mental illness, persons with a complex post-traumatic stress disorder, and
275.27 children with severe emotional disturbance. Services provided under this section must meet
275.28 the relevant standards in sections 245.461 to 245.4887, the Comprehensive Adult and
275.29 Children's Mental Health Acts, Minnesota Rules, parts 9520.0900 to 9520.0926, and
275.30 9505.0322, excluding subpart 10.

275.31 (b) Entities meeting program standards set out in rules governing family community
275.32 support services as defined in section 245.4871, subdivision 17, are eligible for medical
276.1 assistance reimbursement for case management services for children with severe emotional
276.2 disturbance when these services meet the program standards in Minnesota Rules, parts
276.3 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

276.4 (c) Medical assistance and MinnesotaCare payment for mental health case management
276.5 shall be made on a monthly basis. In order to receive payment for an eligible child, the
276.6 provider must document at least a face-to-face contact either in person or by interactive
276.7 video that meets the requirements of subdivision 20b with the child, the child's parents, or
276.8 the child's legal representative. To receive payment for an eligible adult, the provider must
276.9 document:

149.14 (1) at least a face-to-face contact with the adult or the adult's legal representative either
149.15 in person or by interactive video that meets the requirements of subdivision 20b; or

149.16 (2) at least a telephone contact with the adult or the adult's legal representative and
149.17 document a face-to-face contact either in person or by interactive video that meets the
149.18 requirements of subdivision 20b with the adult or the adult's legal representative within the
149.19 preceding two months.

149.20 (d) Payment for mental health case management provided by county or state staff shall
149.21 be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph
149.22 (b), with separate rates calculated for child welfare and mental health, and within mental
149.23 health, separate rates for children and adults.

149.24 (e) Payment for mental health case management provided by Indian health services or
149.25 by agencies operated by Indian tribes may be made according to this section or other relevant
149.26 federally approved rate setting methodology.

149.27 (f) Payment for mental health case management provided by vendors who contract with
149.28 a county must be calculated in accordance with section 256B.076, subdivision 2. Payment
149.29 for mental health case management provided by vendors who contract with a Tribe must
149.30 be based on a monthly rate negotiated by the Tribe. The rate must not exceed the rate charged
149.31 by the vendor for the same service to other payers. If the service is provided by a team of
149.32 contracted vendors, the team shall determine how to distribute the rate among its members.
149.33 No reimbursement received by contracted vendors shall be returned to the county or tribe,
150.1 except to reimburse the county or tribe for advance funding provided by the county or tribe
150.2 to the vendor.

150.3 (g) If the service is provided by a team which includes contracted vendors, tribal staff,
150.4 and county or state staff, the costs for county or state staff participation in the team shall be
150.5 included in the rate for county-provided services. In this case, the contracted vendor, the
150.6 tribal agency, and the county may each receive separate payment for services provided by
150.7 each entity in the same month. In order to prevent duplication of services, each entity must
150.8 document, in the recipient's file, the need for team case management and a description of
150.9 the roles of the team members.

150.10 (h) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for
150.11 mental health case management shall be provided by the recipient's county of responsibility,
150.12 as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds
150.13 used to match other federal funds. If the service is provided by a tribal agency, the nonfederal
150.14 share, if any, shall be provided by the recipient's tribe. When this service is paid by the state
150.15 without a federal share through fee-for-service, 50 percent of the cost shall be provided by
150.16 the recipient's county of responsibility.

150.17 (i) Notwithstanding any administrative rule to the contrary, prepaid medical assistance
150.18 and MinnesotaCare include mental health case management. When the service is provided

276.10 (1) at least a face-to-face contact with the adult or the adult's legal representative either
276.11 in person or by interactive video that meets the requirements of subdivision 20b; or

276.12 (2) at least a telephone contact with the adult or the adult's legal representative and
276.13 document a face-to-face contact either in person or by interactive video that meets the
276.14 requirements of subdivision 20b with the adult or the adult's legal representative within the
276.15 preceding two months.

276.16 (d) Payment for mental health case management provided by county or state staff shall
276.17 be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph
276.18 (b), with separate rates calculated for child welfare and mental health, and within mental
276.19 health, separate rates for children and adults.

276.20 (e) Payment for mental health case management provided by Indian health services or
276.21 by agencies operated by Indian tribes may be made according to this section or other relevant
276.22 federally approved rate setting methodology.

276.23 (f) Payment for mental health case management provided by vendors who contract with
276.24 a county must be calculated in accordance with section 256B.076, subdivision 2. Payment
276.25 for mental health case management provided by vendors who contract with a Tribe must
276.26 be based on a monthly rate negotiated by the Tribe. The rate must not exceed the rate charged
276.27 by the vendor for the same service to other payers. If the service is provided by a team of
276.28 contracted vendors, the team shall determine how to distribute the rate among its members.
276.29 No reimbursement received by contracted vendors shall be returned to the county or tribe,
276.30 except to reimburse the county or tribe for advance funding provided by the county or tribe
276.31 to the vendor.

276.32 (g) If the service is provided by a team which includes contracted vendors, tribal staff,
276.33 and county or state staff, the costs for county or state staff participation in the team shall be
276.34 included in the rate for county-provided services. In this case, the contracted vendor, the
277.1 tribal agency, and the county may each receive separate payment for services provided by
277.2 each entity in the same month. In order to prevent duplication of services, each entity must
277.3 document, in the recipient's file, the need for team case management and a description of
277.4 the roles of the team members.

277.5 (h) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for
277.6 mental health case management shall be provided by the recipient's county of responsibility,
277.7 as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds
277.8 used to match other federal funds. If the service is provided by a tribal agency, the nonfederal
277.9 share, if any, shall be provided by the recipient's tribe. When this service is paid by the state
277.10 without a federal share through fee-for-service, 50 percent of the cost shall be provided by
277.11 the recipient's county of responsibility.

277.12 (i) Notwithstanding any administrative rule to the contrary, prepaid medical assistance
277.13 and MinnesotaCare include mental health case management. When the service is provided

150.19 through prepaid capitation, the nonfederal share is paid by the state and the county pays no
150.20 share.

150.21 (j) The commissioner may suspend, reduce, or terminate the reimbursement to a provider
150.22 that does not meet the reporting or other requirements of this section. The county of
150.23 responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal agency,
150.24 is responsible for any federal disallowances. The county or tribe may share this responsibility
150.25 with its contracted vendors.

150.26 (k) The commissioner shall set aside a portion of the federal funds earned for county
150.27 expenditures under this section to repay the special revenue maximization account under
150.28 section 256.01, subdivision 2, paragraph (n). The repayment is limited to:

150.29 (1) the costs of developing and implementing this section; and

150.30 (2) programming the information systems.

150.31 (l) Payments to counties and tribal agencies for case management expenditures under
150.32 this section shall only be made from federal earnings from services provided under this
150.33 section. When this service is paid by the state without a federal share through fee-for-service,
151.1 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors
151.2 shall include the federal earnings, the state share, and the county share.

151.3 (m) Case management services under this subdivision do not include therapy, treatment,
151.4 legal, or outreach services.

151.5 (n) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital,
151.6 and the recipient's institutional care is paid by medical assistance, payment for case
151.7 management services under this subdivision is limited to the lesser of:

151.8 (1) the last 180 days of the recipient's residency in that facility and may not exceed more
151.9 than six months in a calendar year; or

151.10 (2) the limits and conditions which apply to federal Medicaid funding for this service.

151.11 (o) Payment for case management services under this subdivision shall not duplicate
151.12 payments made under other program authorities for the same purpose.

151.13 (p) If the recipient is receiving care in a hospital, nursing facility, or residential setting
151.14 licensed under chapter 245A or 245D that is staffed 24 hours a day, seven days a week,
151.15 mental health targeted case management services must actively support identification of
151.16 community alternatives for the recipient and discharge planning.

151.17 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
151.18 of human services shall notify the revisor of statutes when federal approval is obtained.

277.14 through prepaid capitation, the nonfederal share is paid by the state and the county pays no
277.15 share.

277.16 (j) The commissioner may suspend, reduce, or terminate the reimbursement to a provider
277.17 that does not meet the reporting or other requirements of this section. The county of
277.18 responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal agency,
277.19 is responsible for any federal disallowances. The county or tribe may share this responsibility
277.20 with its contracted vendors.

277.21 (k) The commissioner shall set aside a portion of the federal funds earned for county
277.22 expenditures under this section to repay the special revenue maximization account under
277.23 section 256.01, subdivision 2, paragraph (n). The repayment is limited to:

277.24 (1) the costs of developing and implementing this section; and

277.25 (2) programming the information systems.

277.26 (l) Payments to counties and tribal agencies for case management expenditures under
277.27 this section shall only be made from federal earnings from services provided under this
277.28 section. When this service is paid by the state without a federal share through fee-for-service,
277.29 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors
277.30 shall include the federal earnings, the state share, and the county share.

277.31 (m) Case management services under this subdivision do not include therapy, treatment,
277.32 legal, or outreach services.

278.1 (n) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital,
278.2 and the recipient's institutional care is paid by medical assistance, payment for case
278.3 management services under this subdivision is limited to the lesser of:

278.4 (1) the last 180 days of the recipient's residency in that facility and may not exceed more
278.5 than six months in a calendar year; or

278.6 (2) the limits and conditions which apply to federal Medicaid funding for this service.

278.7 (o) Payment for case management services under this subdivision shall not duplicate
278.8 payments made under other program authorities for the same purpose.

278.9 (p) If the recipient is receiving care in a hospital, nursing facility, or residential setting
278.10 licensed under chapter 245A or 245D that is staffed 24 hours a day, seven days a week,
278.11 mental health targeted case management services must actively support identification of
278.12 community alternatives for the recipient and discharge planning.

278.13 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
278.14 of human services shall notify the revisor of statutes when federal approval is obtained.

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151.19 Sec. 60. Minnesota Statutes 2024, section 256B.0757, subdivision 4c, is amended to read:

151.20 Subd. 4c. **Behavioral health home services staff qualifications.** (a) A behavioral health
151.21 home services provider must maintain staff with required professional qualifications
151.22 appropriate to the setting.

151.23 (b) If behavioral health home services are offered in a mental health setting, the
151.24 integration specialist must be a licensed nurse, as defined in section 148.171, subdivision
151.25 9.

151.26 (c) If behavioral health home services are offered in a primary care setting, the integration
151.27 specialist must be a mental health professional who is qualified according to section 245I.04,
151.28 subdivision 2.

151.29 (d) If behavioral health home services are offered in either a primary care setting or
151.30 mental health setting, the systems navigator must be a mental health practitioner who is
151.31 qualified according to section 245I.04, subdivision 4, or a community health worker as
151.32 defined in section 256B.0625, subdivision 49.

152.1 (e) If behavioral health home services are offered in either a primary care setting or
152.2 mental health setting, the qualified health home specialist must be one of the following:

152.3 (1) a mental health certified peer specialist who is qualified according to section 245I.04,
152.4 subdivision 10;

152.5 (2) a mental health certified family peer specialist who is qualified according to section
152.6 245I.04, subdivision 12;

152.7 (3) a case management associate as defined in section 245.462, subdivision 4, paragraph
152.8 (g), or 245.4871, subdivision 4, paragraph (j);

152.9 (4) a mental health rehabilitation worker who is qualified according to section 245I.04,
152.10 subdivision 14;

152.11 (5) a community paramedic as defined in section 144E.28, subdivision 9;

152.12 (6) a peer recovery specialist as defined in section ~~245G.07, subdivision 1, clause (5),~~
152.13 245G.11, subdivision 8; or

152.14 (7) a community health worker as defined in section 256B.0625, subdivision 49.

152.15 **EFFECTIVE DATE.** This section is effective July 1, 2026, or upon federal approval,
152.16 whichever is later. The commissioner of human services shall notify the revisor of statutes
152.17 when federal approval is obtained.

181.4 Sec. 31. Minnesota Statutes 2024, section 256B.0757, subdivision 4c, is amended to read:

181.5 Subd. 4c. **Behavioral health home services staff qualifications.** (a) A behavioral health
181.6 home services provider must maintain staff with required professional qualifications
181.7 appropriate to the setting.

181.8 (b) If behavioral health home services are offered in a mental health setting, the
181.9 integration specialist must be a licensed nurse, as defined in section 148.171, subdivision
181.10 9.

181.11 (c) If behavioral health home services are offered in a primary care setting, the integration
181.12 specialist must be a mental health professional who is qualified according to section 245I.04,
181.13 subdivision 2.

181.14 (d) If behavioral health home services are offered in either a primary care setting or
181.15 mental health setting, the systems navigator must be a mental health practitioner who is
181.16 qualified according to section 245I.04, subdivision 4, or a community health worker as
181.17 defined in section 256B.0625, subdivision 49.

181.18 (e) If behavioral health home services are offered in either a primary care setting or
181.19 mental health setting, the qualified health home specialist must be one of the following:

181.20 (1) a mental health certified peer specialist who is qualified according to section 245I.04,
181.21 subdivision 10;

181.22 (2) a mental health certified family peer specialist who is qualified according to section
181.23 245I.04, subdivision 12;

181.24 (3) a case management associate as defined in section 245.462, subdivision 4, paragraph
181.25 (g), or 245.4871, subdivision 4, paragraph (j);

181.26 (4) a mental health rehabilitation worker who is qualified according to section 245I.04,
181.27 subdivision 14;

181.28 (5) a community paramedic as defined in section 144E.28, subdivision 9;

181.29 (6) a peer recovery specialist as defined in section ~~245G.07, subdivision 1, clause (5),~~
181.30 245G.11, subdivision 8; or

181.31 (7) a community health worker as defined in section 256B.0625, subdivision 49.

182.1 **EFFECTIVE DATE.** This section is effective July 1, 2026, or upon federal approval,
182.2 whichever is later. The commissioner of human services shall notify the revisor of statutes
182.3 when federal approval is obtained.

152.18 Sec. 61. Minnesota Statutes 2024, section 256B.0761, subdivision 4, is amended to read:

152.19 Subd. 4. **Services and duration.** (a) Services must be provided 90 days prior to an

152.20 individual's release date or, if an individual's confinement is less than 90 days, during the

152.21 time period between a medical assistance eligibility determination and the release to the

152.22 community.

152.23 (b) Facilities must offer the following services using either community-based or

152.24 corrections-based providers:

152.25 (1) case management activities to address physical and behavioral health needs, including

152.26 a comprehensive assessment of individual needs, development of a person-centered care

152.27 plan, referrals and other activities to address assessed needs, and monitoring and follow-up

152.28 activities;

152.29 (2) drug coverage in accordance with section 256B.0625, subdivision 13, including up

152.30 to a 30-day supply of drugs upon release;

153.1 (3) substance use disorder comprehensive assessments according to section 254B.05,

153.2 subdivision 5, paragraph (b), clause (2);

153.3 (4) treatment coordination services according to section 254B.05, subdivision 5, paragraph

153.4 (b), clause (3);

153.5 (5) peer recovery support services according to sections 245I.04, subdivisions 18 and

153.6 19, and 254B.05, subdivision 5, paragraph (b), clause (4);

153.7 (6) substance use disorder individual and group counseling provided according to sections

153.8 245G.07, subdivision 1, paragraph (a), clause (1), and 254B.05;

153.9 (7) mental health diagnostic assessments as required under section 245I.10;

153.10 (8) group and individual psychotherapy as required under section 256B.0671;

153.11 (9) peer specialist services as required under sections 245I.04 and 256B.0615;

153.12 (10) family planning and obstetrics and gynecology services; ~~and~~

153.13 (11) physical health well-being and screenings and care for adults and youth; ~~and~~

153.14 (12) medications used for the treatment of opioid use disorder and nonmedication

153.15 treatment services for opioid use disorder under section 245G.22.

153.16 (c) Services outlined in this subdivision must only be authorized when an individual

153.17 demonstrates medical necessity or other eligibility as required under this chapter or applicable

153.18 state and federal laws.

182.4 Sec. 32. Minnesota Statutes 2024, section 256B.0761, subdivision 4, is amended to read:

182.5 Subd. 4. **Services and duration.** (a) Services must be provided 90 days prior to an

182.6 individual's release date or, if an individual's confinement is less than 90 days, during the

182.7 time period between a medical assistance eligibility determination and the release to the

182.8 community.

182.9 (b) Facilities must offer the following services using either community-based or

182.10 corrections-based providers:

182.11 (1) case management activities to address physical and behavioral health needs, including

182.12 a comprehensive assessment of individual needs, development of a person-centered care

182.13 plan, referrals and other activities to address assessed needs, and monitoring and follow-up

182.14 activities;

182.15 (2) drug coverage in accordance with section 256B.0625, subdivision 13, including up

182.16 to a 30-day supply of drugs upon release;

182.17 (3) substance use disorder comprehensive assessments according to section 254B.05,

182.18 subdivision 5, paragraph (b), clause (2);

182.19 (4) treatment coordination services according to section 254B.05, subdivision 5, paragraph

182.20 (b), clause (3);

182.21 (5) peer recovery support services according to sections 245I.04, subdivisions 18 and

182.22 19, and 254B.05, subdivision 5, paragraph (b), clause (4);

182.23 (6) substance use disorder individual and group counseling provided according to sections

182.24 245G.07, subdivision 1, paragraph (a), clause (1), and 254B.05;

182.25 (7) mental health diagnostic assessments as required under section 245I.10;

182.26 (8) group and individual psychotherapy as required under section 256B.0671;

182.27 (9) peer specialist services as required under sections 245I.04 and 256B.0615;

182.28 (10) family planning and obstetrics and gynecology services; ~~and~~

182.29 (11) physical health well-being and screenings and care for adults and youth; and

182.30 (12) medications and nonmedication treatment services for opioid use disorder under

182.31 section 245G.22.

183.1 (c) Services outlined in this subdivision must only be authorized when an individual

183.2 demonstrates medical necessity or other eligibility as required under this chapter or applicable

183.3 state and federal laws.

183.4 Sec. 33. Minnesota Statutes 2024, section 256B.761, is amended to read:

183.5 **256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.**

183.6 (a) Effective for services rendered on or after July 1, 2001, payment for medication
183.7 management provided to psychiatric patients, outpatient mental health services, day treatment
183.8 services, home-based mental health services, and family community support services shall
183.9 be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the 50th percentile of
183.10 1999 charges.

183.11 (b) Effective July 1, 2001, the medical assistance rates for outpatient mental health
183.12 services provided by an entity that operates: (1) a Medicare-certified comprehensive
183.13 outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1, 1993,
183.14 with at least 33 percent of the clients receiving rehabilitation services in the most recent
183.15 calendar year who are medical assistance recipients, will be increased by 38 percent, when
183.16 those services are provided within the comprehensive outpatient rehabilitation facility and
183.17 provided to residents of nursing facilities owned by the entity.

183.18 (c) In addition to rate increases otherwise provided, the commissioner may restructure
183.19 coverage policy and rates to improve access to adult rehabilitative mental health services
183.20 under section 256B.0623 and related mental health support services under section 256B.021,
183.21 subdivision 4, paragraph (f), clause (2). For state fiscal years 2015 and 2016, the projected
183.22 state share of increased costs due to this paragraph is transferred from adult mental health
183.23 grants under sections 245.4661 and 256K.10. The transfer for fiscal year 2016 is a permanent
183.24 base adjustment for subsequent fiscal years. Payments made to managed care plans and
183.25 county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect
183.26 the rate changes described in this paragraph.

183.27 (d) Any ratables effective before July 1, 2015, do not apply to early intensive
183.28 developmental and behavioral intervention (EIDBI) benefits described in section 256B.0949.

183.29 (e) Effective for services rendered on or after January 1, 2024, payment rates for
183.30 behavioral health services included in the rate analysis required by Laws 2021, First Special
183.31 Session chapter 7, article 17, section 18, except for adult day treatment services under section
183.32 256B.0671, subdivision 3; early intensive developmental and behavioral intervention services
183.33 under section 256B.0949; and substance use disorder services under chapter 254B, must be
184.1 increased by three percent from the rates in effect on December 31, 2023. Effective for
184.2 services rendered on or after January 1, 2025, payment rates for behavioral health services
184.3 included in the rate analysis required by Laws 2021, First Special Session chapter 7, article
184.4 17, section 18, and early intensive developmental behavioral intervention services under
184.5 section 256B.0949, and substance use disorder services under chapter 254B, must be annually
184.6 adjusted according to the change from the midpoint of the previous rate year to the midpoint
184.7 of the rate year for which the rate is being determined using the Centers for Medicare and
184.8 Medicaid Services Medicare Economic Index as forecasted in the fourth quarter of the
184.9 calendar year before the rate year. For payments made in accordance with this paragraph,
184.10 if and to the extent that the commissioner identifies that the state has received federal

153.19 Sec. 62. Minnesota Statutes 2024, section 256I.04, subdivision 2a, is amended to read:

153.20 Subd. 2a. **License required; staffing qualifications.** (a) Except as provided in paragraph

153.21 ~~(b)~~ (c), an agency may not enter into an agreement with an establishment to provide housing

153.22 support unless:

153.23 (1) the establishment is licensed by the Department of Health as a hotel and restaurant;

153.24 a board and lodging establishment; a boarding care home before March 1, 1985; or a

153.25 supervised living facility, and the service provider for residents of the facility is licensed

153.26 under chapter 245A. However, an establishment licensed by the Department of Health to

153.27 provide lodging need not also be licensed to provide board if meals are being supplied to

153.28 residents under a contract with a food vendor who is licensed by the Department of Health;

153.29 (2) the residence is: (i) licensed by the commissioner of human services under Minnesota

153.30 Rules, parts 9555.5050 to 9555.6265; (ii) certified by a county human services agency prior

153.31 to July 1, 1992, using the standards under Minnesota Rules, parts 9555.5050 to 9555.6265;

154.1 (iii) licensed by the commissioner under Minnesota Rules, parts 2960.0010 to 2960.0120,

154.2 with a variance under section 245A.04, subdivision 9; or (iv) licensed under section 245D.02,

154.3 subdivision 4a, as a community residential setting by the commissioner of human services;

154.4 or

154.5 (3) the facility is licensed under chapter 144G and provides three meals a day.

184.11 financial participation for behavioral health services in excess of the amount allowed under

184.12 United States Code, title 42, section 447.321, the state shall repay the excess amount to the

184.13 Centers for Medicare and Medicaid Services with state money and maintain the full payment

184.14 rate under this paragraph. This paragraph does not apply to federally qualified health centers,

184.15 rural health centers, Indian health services, certified community behavioral health clinics,

184.16 cost-based rates, and rates that are negotiated with the county. This paragraph expires upon

184.17 legislative implementation of the new rate methodology resulting from the rate analysis

184.18 required by Laws 2021, First Special Session chapter 7, article 17, section 18.

184.19 (f) Effective January 1, 2024, the commissioner shall increase capitation payments made

184.20 to managed care plans and county-based purchasing plans to reflect the behavioral health

184.21 service rate increase provided in paragraph (e). Managed care and county-based purchasing

184.22 plans must use the capitation rate increase provided under this paragraph to increase payment

184.23 rates to behavioral health services providers. The commissioner must monitor the effect of

184.24 this rate increase on enrollee access to behavioral health services. If for any contract year

184.25 federal approval is not received for this paragraph, the commissioner must adjust the

184.26 capitation rates paid to managed care plans and county-based purchasing plans for that

184.27 contract year to reflect the removal of this provision. Contracts between managed care plans

184.28 and county-based purchasing plans and providers to whom this paragraph applies must

184.29 allow recovery of payments from those providers if capitation rates are adjusted in accordance

184.30 with this paragraph. Payment recoveries must not exceed the amount equal to any increase

184.31 in rates that results from this provision.

154.6 (b) Effective January 1, 2027, the commissioner may enter into housing support
154.7 agreements with a board and lodging establishment under section 256I.04, subdivision 2a,
154.8 paragraph (a), clause (1), that is also certified by the commissioner as a recovery residence,
154.9 subject to the requirements of section 256I.04, subdivisions 2a to 2f. When doing so, the
154.10 department of human services serves as the lead agency for the agreement.

154.11 ~~(b)~~ (c) The requirements under paragraph (a) do not apply to establishments exempt
154.12 from state licensure because they are:

154.13 (1) located on Indian reservations and subject to tribal health and safety requirements;
154.14 or

154.15 (2) supportive housing establishments where an individual has an approved habitability
154.16 inspection and an individual lease agreement.

154.17 ~~(c)~~ (d) Supportive housing establishments that serve individuals who have experienced
154.18 long-term homelessness and emergency shelters must participate in the homeless management
154.19 information system and a coordinated assessment system as defined by the commissioner.

154.20 ~~(d)~~ (e) Effective July 1, 2016, an agency shall not have an agreement with a provider of
154.21 housing support unless all staff members who have direct contact with recipients:

154.22 (1) have skills and knowledge acquired through one or more of the following:

154.23 (i) a course of study in a health- or human services-related field leading to a bachelor
154.24 of arts, bachelor of science, or associate's degree;

154.25 (ii) one year of experience with the target population served;

154.26 (iii) experience as a mental health certified peer specialist according to section 256B.0615;
154.27 or

154.28 (iv) meeting the requirements for unlicensed personnel under sections 144A.43 to
154.29 144A.483;

154.30 (2) hold a current driver's license appropriate to the vehicle driven if transporting
154.31 recipients;

155.1 (3) complete training on vulnerable adults mandated reporting and child maltreatment
155.2 mandated reporting, where applicable; and

155.3 (4) complete housing support orientation training offered by the commissioner.

155.4 Sec. 63. Minnesota Statutes 2024, section 325F.725, is amended to read:

155.5 **325F.725 SOBER HOME RECOVERY RESIDENCE TITLE PROTECTION.**

155.6 No person or entity may use the phrase "~~sober home~~," "recovery residence," whether
155.7 alone or in combination with other words and whether orally or in writing, to advertise,
155.8 market, or otherwise describe, offer, or promote itself, or any housing, service, service

- 155.9 package, or program that it provides within this state, unless the person or entity meets the
155.10 definition of a ~~sober home~~ recovery residence in section 254B.01, subdivision 11, and meets
155.11 the requirements of ~~section 254B.18~~ sections 254B.21 to 254B.216.
- 155.12 **EFFECTIVE DATE.** This section is effective January 1, 2027.
- 155.13 Sec. 64. **RECOVERY RESIDENCE WORKGROUP.**
- 155.14 (a) The commissioner of human services must convene a workgroup to develop
155.15 recommendations specific to recovery residences. The workgroup must:
- 155.16 (1) produce a report that examines how other states fund recovery residences, identifying
155.17 best practices and models that could be applicable to Minnesota;
- 155.18 (2) engage with stakeholders to ensure meaningful collaboration with key external
155.19 stakeholders on the ideas being developed that will inform the final plan and
155.20 recommendations; and
- 155.21 (3) create an implementable plan addressing housing needs for individuals in outpatient
155.22 substance use disorder treatment that includes:
- 155.23 (i) clear strategies for aligning housing models with individual treatment needs;
- 155.24 (ii) an assessment of funding streams, including potential federal funding sources;
- 155.25 (iii) a timeline for implementation with key milestones and action steps;
- 155.26 (iv) recommendations for future resource allocation to ensure long-term housing stability
155.27 for individuals in recovery;
- 155.28 (v) specific recommendations for policy or legislative changes that may be required to
155.29 support sustainable recovery housing solutions, including challenges faced by recovery
155.30 residences resulting from state and local housing regulations and ordinances; and
- 156.1 (vi) recommendations for potentially delegating the commissioner's recovery residence
156.2 certification duties under Minnesota Statutes, sections 254B.21 to 254B.216 to a third-party
156.3 organization.
- 156.4 (b) The workgroup must include but is not limited to:
- 156.5 (1) at least two designees from the Department of Human Services representing: (i)
156.6 behavioral health; and (ii) homelessness and housing and support services;
- 156.7 (2) the commissioner of health or a designee;
- 156.8 (3) two people who have experience living in a recovery residence;
- 156.9 (4) representatives from at least three substance use disorder lodging facilities currently
156.10 operating in Minnesota;

- 156.11 (5) three representatives from county social services agencies, at least one from inside
156.12 the seven-county metropolitan area and one from outside the seven-county metropolitan
156.13 area;
- 156.14 (6) a representative from a Tribal social services agency;
- 156.15 (7) representatives from the state affiliate of the National Alliance for Recovery
156.16 Residences; and
- 156.17 (8) a representative from a state mental health advocacy or adult mental health provider
156.18 organization.
- 156.19 (c) The workgroup must meet at least monthly and as necessary to fulfill its
156.20 responsibilities. The commissioner of human services must provide administrative support
156.21 and meeting space for the workgroup. The workgroup may conduct meetings remotely.
- 156.22 (d) The commissioner of human services must make appointments to the workgroup by
156.23 October 1, 2025, and convene the first meeting of the workgroup by January 15, 2026.
- 156.24 (e) The workgroup must submit a final report with recommendations to the chairs and
156.25 ranking minority members of the legislative committees with jurisdiction over health and
156.26 human services policy and finance on or before January 1, 2027.
- 156.27 Sec. 65. **SUBSTANCE USE DISORDER TREATMENT COORDINATION AND**
156.28 **NAVIGATION ASSISTANCE EVALUATION.**
- 156.29 (a) The commissioner of human services must evaluate and make recommendations on
156.30 ways to ensure that persons with substance use disorder have access to treatment coordination
156.31 and navigation services that improve access to:
- 157.1 (1) acute withdrawal services;
- 157.2 (2) physical health care coverage and services;
- 157.3 (3) cognitive, behavioral, and emotional health care coverage and services;
- 157.4 (4) relapse prevention services; and
- 157.5 (5) recovery environment supports, including but not limited to employment, vocational
157.6 services, transportation, child care, affordable housing, economic assistance, financial
157.7 independence, and reconnection to community.
- 157.8 (b) As part of the evaluation, the commissioner must assess and identify gaps in the
157.9 current substance use disorder service continuum including treatment coordination, health
157.10 care navigation services, and case management. The commissioner must evaluate
157.11 opportunities and make recommendations for developing, expanding, or integrating medical
157.12 assistance care coordination, navigation, and case management services.
- 157.13 (c) The commissioner must submit a report on the evaluation and recommendations
157.14 under this section to the chairs and ranking minority members of the committees with

157.15 jurisdiction over health and human services by November 1, 2026. The report must outline
157.16 currently available treatment coordination and navigation services for persons with substance
157.17 use disorder, identify gaps in the substance use disorder service continuum, and recommend
157.18 new, expanded, or integrated benefits that align with evidence-based, holistic, and
157.19 person-centered approaches to substance use disorder recovery.

157.20 Sec. 66. **PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY WORKING**
157.21 **GROUP.**

157.22 (a) By July 15, 2025, the commissioner of human services must convene a working
157.23 group with participation from:

157.24 (1) organizations operating psychiatric residential treatment facilities;

157.25 (2) advocates;

157.26 (3) health care experts;

157.27 (4) juvenile detention experts;

157.28 (5) county representatives;

157.29 (6) at least one employee of Direct Care and Treatment appointed by the chief executive
157.30 officer of Direct Care and Treatment;

158.1 (7) at least one employee of the Department of Health appointed by the commissioner
158.2 of health; and

158.3 (8) at least two employees of the Department of Human Services, one of whom must
158.4 have expertise in behavioral health and one of whom must have expertise in licensing of
158.5 residential facilities.

158.6 (b) By January 15, 2026, the psychiatric residential treatment facility working group
158.7 must submit a report and proposed legislative changes to the chairs and ranking minority
158.8 members of the legislative committees with jurisdiction over children's mental health and
158.9 juvenile detention. The submitted report must include recommendations:

158.10 (1) to amend the state medical assistance plan to expand access to care provided in
158.11 psychiatric residential treatment facilities with consideration being given to enhancing
158.12 flexibilities to serve a continuum of mental health needs;

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279.1 Sec. 15. **PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY REPORT.**

279.2 (a) By January 15, 2026, the commissioner of human services, in consultation with
279.3 organizations operating psychiatric residential treatment facilities, advocates, health care
279.4 experts, juvenile detention experts, and county representatives, must submit a report and
279.5 proposed legislative changes to the chairs and ranking minority members of the legislative
279.6 committees with jurisdiction over children's mental health and juvenile detention. The
279.7 submitted report must include recommendations on:

279.8 (1) amending the state medical assistance plan to expand access to care provided in
279.9 psychiatric residential treatment facilities, with consideration being given to enhancing
279.10 flexibilities to serve a continuum of mental health needs;

158.13 (2) to develop licensing standards for psychiatric residential treatment facilities to reflect
158.14 needed flexibilities and broad inclusion of settings where care can be delivered in settings
158.15 operated by Direct Care and Treatment; and

158.16 (3) to update the rate methodology for services provided in psychiatric residential
158.17 treatment facilities to assure high quality of care with required individualization.

158.18 (c) When developing the recommendations required under paragraph (b), the working
158.19 group must:

158.20 (1) consider how best to meet the needs of children with high levels of complexity,
158.21 aggression, and related barriers to being served by community providers; and

158.22 (2) determine what would be required, including needed infrastructure, staffing, and
158.23 sustainable funding sources, to allow qualified residential treatment programs to transition
158.24 to a psychiatric residential treatment facility standard of care.

158.25 **EFFECTIVE DATE.** This section is effective the day following final enactment.

158.26 Sec. 67. **SUBSTANCE USE DISORDER TREATMENT BILLING UNITS.**

158.27 The commissioner of human services must establish six new billing codes for
158.28 nonresidential substance use disorder individual and group counseling, psychoeducation,
158.29 and recovery support services. The commissioner must identify reimbursement rates for
158.30 the newly defined codes and update the substance use disorder fee schedule. The new billing
158.31 codes must correspond to a 15-minute unit and become effective for services provided on
158.32 or after July 1, 2026, or upon federal approval, whichever is later.

279.11 (2) developing licensing standards for psychiatric residential treatment facilities that
279.12 reflect needed flexibilities and the broad inclusion of settings where care can be delivered;
279.13 and

279.14 (3) updating the rate methodology for services provided in psychiatric residential
279.15 treatment facilities to assure high quality of care with required individualization.

279.16 (b) When developing the recommendations required under paragraph (a), the
279.17 commissioner must:

279.18 (1) consider how best to meet the needs of children with high levels of complexity,
279.19 aggression, and other related barriers to being served by community providers; and

279.20 (2) determine what would be required, including needed infrastructure, staffing, and
279.21 sustainable funding sources, to allow qualified residential treatment programs to transition
279.22 to a psychiatric residential treatment facility standard of care.

279.23 **EFFECTIVE DATE.** This section is effective the day following final enactment.

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184.32 Sec. 34. **DIRECTION TO COMMISSIONER; SUBSTANCE USE DISORDER**
184.33 **TREATMENT STAFF REPORT AND RECOMMENDATIONS.**

184.34 The commissioner of human services must, in consultation with the Board of Nursing,
184.35 Board of Behavioral Health and Therapy, and Board of Medical Practice, conduct a study
185.1 and develop recommendations to the legislature for amendments to Minnesota Statutes,
185.2 chapter 245G, that would eliminate any limitations on licensed health professionals' ability
185.3 to provide substance use disorder treatment services while practicing within their licensed
185.4 or statutory scopes of practice. The commissioner must submit a report on the study and
185.5 recommendations to the chairs and ranking minority members of the legislative committees
185.6 with jurisdiction over human services finance and policy by January 15, 2027.

185.7 Sec. 35. **DIRECTION TO THE COMMISSIONER; SUBSTANCE USE DISORDER**
185.8 **TREATMENT BILLING UNITS.**

185.9 The commissioner of human services must establish six new billing codes for
185.10 nonresidential substance use disorder individual and group counseling, individual and group
185.11 psychoeducation, and individual and group recovery support services. The commissioner
185.12 must identify reimbursement rates for the newly defined codes and update the substance
185.13 use disorder fee schedule. The new billing codes must correspond to a 15-minute unit and
185.14 become effective for services provided on or after July 1, 2026, or upon federal approval,
185.15 whichever is later.

185.16 **EFFECTIVE DATE.** This section is effective July 1, 2026, or upon federal approval,
185.17 whichever is later. The commissioner of human services must inform the revisor of statutes
185.18 when federal approval is obtained.

185.19	Sec. 36. REVISOR INSTRUCTION.	
185.20	The revisor of statutes, in consultation with the House Research Department; the Office	
185.21	of Senate Counsel, Research and Fiscal Analysis; and the Department of Human Services	
185.22	shall make necessary cross-reference changes and remove statutory cross-references in	
185.23	Minnesota Statutes to conform with the renumbering in this act. The revisor may make	
185.24	technical and other necessary changes to sentence structure to preserve the meaning of the	
185.25	text. The revisor may alter the coding in this act to incorporate statutory changes made by	
185.26	other law in the 2025 regular legislative session or a special session. If a provision stricken	
185.27	in this act is also amended in the 2025 regular legislative session or a special session by	
185.28	other law, the revisor shall merge the amendment into the numbering, notwithstanding	
185.29	Minnesota Statutes, section 645.30.	
186.1	Sec. 37. REVISOR INSTRUCTION.	
186.2	The revisor of statutes shall renumber each provision of Minnesota Statutes listed in	
186.3	column A as amended in this act to the number listed in column B. The revisor shall also	
186.4	make necessary cross-reference changes consistent with the renumbering.	
186.5	<u>Column A</u>	<u>Column B</u>
186.6	<u>254B.05, subdivision 1, paragraph (a)</u>	<u>254B.0501, subdivision 1</u>
186.7	<u>254B.05, subdivision 1, paragraph (i)</u>	<u>254B.0501, subdivision 2</u>
186.8	<u>254B.05, subdivision 4</u>	<u>254B.0501, subdivision 3</u>
186.9	<u>254B.05, subdivision 1, paragraph (b)</u>	<u>254B.0501, subdivision 4</u>
186.10	<u>254B.05, subdivision 1, paragraph (c)</u>	<u>254B.0501, subdivision 5</u>
186.11	<u>254B.05, subdivision 1, paragraph (d)</u>	<u>254B.0501, subdivision 6, paragraph (a)</u>
186.12	<u>254B.05, subdivision 1, paragraph (e)</u>	<u>254B.0501, subdivision 6, paragraph (b)</u>
186.13	<u>254B.05, subdivision 1, paragraph (f)</u>	<u>254B.0501, subdivision 6, paragraph (c)</u>
186.14	<u>254B.05, subdivision 1, paragraph (g)</u>	<u>254B.0501, subdivision 6, paragraph (d)</u>
186.15	<u>254B.05, subdivision 1, paragraph (h)</u>	<u>254B.0501, subdivision 7</u>
186.16	<u>254B.05, subdivision 1b</u>	<u>254B.0501, subdivision 8</u>
186.17	<u>254B.05, subdivision 2</u>	<u>254B.0501, subdivision 9</u>
186.18	<u>254B.05, subdivision 3</u>	<u>254B.0501, subdivision 10</u>

186.19	<u>254B.05, subdivision 1a, paragraph (a)</u>	<u>254B.0503, subdivision 1, paragraph (a)</u>
186.20	<u>254B.05, subdivision 1a, paragraph (c)</u>	<u>254B.0503, subdivision 1, paragraph (b)</u>
186.21	<u>254B.05, subdivision 1a, paragraph (d)</u>	<u>254B.0503, subdivision 1, paragraph (c)</u>
186.22	<u>254B.05, subdivision 1a, paragraph (e)</u>	<u>254B.0503, subdivision 1, paragraph (d)</u>
186.23	<u>254B.05, subdivision 1a, paragraph (b)</u>	<u>254B.0503, subdivision 2, paragraph (a)</u>
186.24	<u>254B.05, subdivision 1a, paragraph (e)</u>	<u>254B.0503, subdivision 2, paragraph (b)</u>
186.25	<u>254B.05, subdivision 5, paragraph (a)</u>	<u>254B.0505, subdivision 1</u>
186.26	<u>254B.05, subdivision 5, paragraph (c)</u>	<u>254B.0505, subdivision 2</u>
186.27	<u>254B.05, subdivision 5, paragraph (d)</u>	<u>254B.0505, subdivision 3</u>
186.28	<u>254B.05, subdivision 5, paragraph (e)</u>	<u>254B.0505, subdivision 4</u>
186.29	<u>254B.05, subdivision 5, paragraph (f)</u>	<u>254B.0505, subdivision 5</u>
186.30	<u>254B.05, subdivision 5, paragraph (g)</u>	<u>254B.0505, subdivision 6</u>
186.31	<u>254B.05, subdivision 5, paragraph (h)</u>	<u>254B.0505, subdivision 7</u>
186.32	<u>254B.05, subdivision 5, paragraph (i)</u>	<u>254B.0505, subdivision 8</u>
186.33	<u>254B.05, subdivision 5, paragraph (b), first</u>	<u>254B.0507, subdivision 1</u>
186.34	<u>sentence</u>	
186.35	<u>254B.05, subdivision 5, paragraph (b), clause</u>	<u>254B.0507, subdivision 2, paragraph (a)</u>
186.36	<u>(1), items (i) and (ii)</u>	
186.37	<u>254B.05, subdivision 5, paragraph (b), block</u>	<u>254B.0507, subdivision 2, paragraph (b)</u>
186.38	<u>left paragraph</u>	
187.1	<u>254B.05, subdivision 5, paragraph (b), clause</u>	<u>254B.0507, subdivision 3</u>
187.2	<u>(2)</u>	
187.3	<u>254B.05, subdivision 5, paragraph (b), clause</u>	<u>254B.0507, subdivision 4</u>
187.4	<u>(3)</u>	
187.5	<u>254B.05, subdivision 5, paragraph (b), clause</u>	<u>254B.0507, subdivision 5</u>
187.6	<u>(4)</u>	

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187.7	<u>254B.05, subdivision 5, paragraph (b), clause</u>	<u>254B.0507, subdivision 6, paragraph (a)</u>			
187.8	<u>(5)</u>				
187.9	<u>254B.05, subdivision 5, paragraph (b), clause</u>	<u>254B.0507, subdivision 6, paragraph (b)</u>			
187.10	<u>(5), block left paragraph</u>				
187.11	<u>254B.05, subdivision 6, paragraph (a)</u>	<u>254B.0509, subdivision 1</u>			
187.12	<u>254B.05, subdivision 6, paragraph (b)</u>	<u>254B.0509, subdivision 2</u>			
187.13	<u>254B.05, subdivision 1, paragraph (j)</u>	<u>254B.052, subdivision 4</u>			
187.14	<u>254B.05, subdivision 5, paragraph (j)</u>	<u>254B.052, subdivision 5</u>			
159.1	Sec. 68. <u>REVISOR INSTRUCTION.</u>		187.15	Sec. 38. <u>REVISOR INSTRUCTION.</u>	
159.2	<u>The revisor of statutes shall change the terms "mental health practitioner" and "mental</u>		187.16	<u>health practitioners" to "behavioral health practitioner" and "behavioral health practitioners"</u>	
159.3	<u>health practitioners" to "behavioral health practitioner" or "behavioral health practitioners"</u>		187.17	<u>wherever they appear in Minnesota Statutes, chapter 245I.</u>	
159.4	<u>wherever they appear in Minnesota Statutes, chapter 245I.</u>			UEH2435-1	
			278.15	Sec. 14. <u>MENTAL HEALTH COLLABORATION HUB INNOVATION PILOT</u>	
			278.16	<u>PROGRAM.</u>	
			278.17	<u>(a) The commissioner of human services must support the Mental Health Collaboration</u>	
			278.18	<u>Hub's pilot project to develop and implement innovative care pathways and care facility</u>	
			278.19	<u>decompression strategies by providing funding support and technical assistance and entering</u>	
			278.20	<u>into a data-sharing agreement with the Mental Health Collaboration Hub. The pilot project</u>	
			278.21	<u>must fund, track, and evaluate activities that expedite transitions of children from</u>	
			278.22	<u>inappropriate care settings to appropriate care settings. A steering committee of expert</u>	
			278.23	<u>Mental Health Collaboration Hub participants that represent the continuum of children's</u>	
			278.24	<u>behavioral health care must guide funding determinations to support the transition of up to</u>	
			278.25	<u>200 children per year.</u>	
			278.26	<u>(b) On January 1, 2027, and January 1, 2028, the Mental Health Collaboration Hub must</u>	
			278.27	<u>submit a report to the commissioner and chairs and ranking minority members of the</u>	
			278.28	<u>legislative committees with jurisdiction over children's mental health and juvenile detention.</u>	
			278.29	<u>The report must describe how the grant money was spent and summarize the impact the</u>	
			278.30	<u>pilot project had on participating children, families, and providers.</u>	
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159.5	Sec. 69. <u>REPEALER.</u>		187.19	Sec. 39. <u>REPEALER.</u>	
159.6	<u>(a) Minnesota Statutes 2024, sections 245G.01, subdivision 20d; 245G.07, subdivision</u>		187.20	<u>Minnesota Statutes 2024, sections 245G.01, subdivision 20d; 245G.07, subdivision 2;</u>	
159.7	<u>2; and 254B.01, subdivision 5, are repealed.</u>		187.21	<u>254B.01, subdivision 5; and 254B.18, are repealed.</u>	

- 159.8 (b) Minnesota Statutes 2024, section 254B.04, subdivision 2a, is repealed.
- 159.9 (c) Minnesota Statutes 2024, section 254B.181, is repealed.
- 159.10 **EFFECTIVE DATE.** Paragraph (a) is effective July 1, 2025, paragraph (b) is effective
- 159.11 July 1, 2027, and paragraph (c) is effective January 1, 2027.
- 187.22 **EFFECTIVE DATE.** This section is effective July 1, 2025.